STATE OF MICHIGAN

IN THE SUPREME COURT

APPEAL FROM THE MICHIGAN COURT OF APPEALS AFTER REMAND
Hon. Helene N. White, Presiding Judge

RICHARD ADAM KREINER,

Plaintiff-Appellee,

v. **Supreme Court No. 124120**

ROBERT OAKLAND FISCHER

Defendant-Appellant.

Court of Appeals No. 225640
Lapeer County Circuit Court No. 98-026072-NI

BRIEF OF PLAINTIFF-APPELLEE RICHARD ADAM KREINER

PROOF OF SERVICE

* * * ORAL ARGUMENT REQUESTED * * *

GEORGE T. SINAS (P25643)
SINAS, DRAMIS, BRAKE,
BOUGHTON & McINTYRE P.C.
3380 Pine Tree Road
Lansing, Michigan 48911
(517) 394-7500

TERRY L. COCHRAN (P35890)
COCHRAN, FOLEY
& ASSOCIATES, P.C.
15510 Farmington Road
Livonia, Michigan 48154
(734) 425-2400

CHARLES J. COOPER (*pro hac vice*)
HAMISH P.M. HUME
DEREK L. SHAFFER
COOPER & KIRK, PLLC
1500 K Street, N.W.
Suite 200
Washington, D.C. 20005
(202) 220-9600

Attorneys for RICHARD ADAM KREINER

March 8, 2004

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES iii

INTRODUCTION 1

STATEMENT OF JURISDICTION 4

COUNTER-STATEMENT OF QUESTION INVOLVED 4

RELEVANT STATUTORY PROVISIONS 4

STANDARD OF REVIEW 5

COUNTER-STATEMENT OF FACTS AND PROCEEDINGS 6

A. Facts. 6

B. Proceedings. 10

LEGISLATIVE AND JUDICIAL BACKGROUND 12

SUMMARY OF ARGUMENT 16

ARGUMENT 17

I. UNDER THE 1995 AMENDMENTS, A PLAINTIFF WHO DEMONSTRATES THAT AN IMPAIRMENT HAD AN EFFECT ON HIS NORMAL LIFE SATISFIES THE THRESHOLD TO SUE IN TORT 19

II. THE LEGISLATURE DID NOT INTEND THE WORD "GENERAL" TO IMPOSE A SECOND SERIOUSNESS REQUIREMENT 26

A. The Phrase "General Ability" Simply Refers To A Singular And Unqualified "Ability" 27

B. Defendant's And ACIA's Interpretation Of The Word "General" Would Produce Nonsensical Results 33

C. This Court Has Already Recognized The Difference Between A "Serious Impairment," Which The Legislature Has Required, And A "Serious Effect," Which It Has Not 39

D. This Court Should Reject Defendant's Suggestion To Add Additional Prongs To The Statutory Definition Of "Serious Impairment Of A Body Function" 42

III. THE COURT OF APPEALS DECISION ON REMAND ILLUSTRATES THE PROPER APPLICATION OF THE "GENERAL ABILITY" PRONG 46

CONCLUSION 49

MCL § 500.3135 ..... ADDENDUM 1

Proposal D, Ballot Question in Michigan's 1992 General Election ..... ADDENDUM 2

Proposal C, Ballot Question in Michigan's 1994 General Election ..... ADDENDUM 3

TABLE OF AUTHORITIES

Cases **Page**

Adams Outdoor Adver, Inc v Holland, 463 Mich 675, 625 NW2d 377 (2001) 5

Blue Cross & Blue Shield v Milliken, 422 Mich 1, 367 NW2d 1 (1985) 44

Cassidy v McGovern, 415 Mich 483, 330 NW2d 22 (1982) 14, 21

Commissioner of Internal Revenue v Groetzinger, 480 US 23, 107 S Ct 980, 94 L Ed 2d 25 (1987) 44

Concerned Citizens of Southern Ohio, Inc v Pine Creek Conservancy Dist, 429 US 651, 97 S Ct 828, 51 L Ed 2d 116 (1977) 32

Cox v Board of Hospital Managers for the City of Flint, 467 Mich 1, 651 NW2d 356 (2002) 31, 32

Daley v LaCroix, 384 Mich 4, 179 NW2d 390 (1970) 45

DiFranco v Pickard, 427 Mich 32, 398 NW2d 896 (1986) ..... *passim*

Franz v Woods, 145 Mich App 169, 377 NW2d 373 (1985) 21

Hanson v Mecosta Co Rd Comm'rs, 465 Mich 492, 638 NW2d 396 (2002) 28

Illinois v Gates, 462 US 213, 103 S Ct 2317, 76 L Ed 527 (1983) 44

Kendell v Bishop, 76 Mich 634, 43 NW 645 (1889) 32

Kern v Blethen-Coluni, 240 Mich App 333, 612 NW2d 838 (2000) 43

Kreiner v Fischer, 251 Mich App 513, 651 NW2d 433 (2002), *vacated and remanded*, 468 Mich 884, 661 NW2d 234 (2003) 10, 11

Kreiner v Fischer (on remand), 256 Mich App 680, 671 NW2d 95 (2003) ..... *passim*

Kreiner v Fischer, 468 Mich 884, 661 NW2d 234 (2003) 11, 19, 40

Lytle v Malady, 458 Mich 153, 579 NW2d 906 (1998) 28

Michigan v Jackson, 475 US 625, 106 S Ct 1404, 89 L Ed 2d 631 (1986) 44, 45

Moran v Commissioner of Internal Revenue, 309 US 78, 60 S Ct 424, 84 L Ed 585 (1940) 33

Owens v Detroit, 163 Mich App 134, 413 NW2d 679 (1987) 21

Parkwood Ltd Dividend Hous Ass'n v State House Dev Auth, 468 Mich 763, 664 NW2d 185 (2003) 28

Rednour v Hastings Mut Ins Co, 468 Mich 241, 661 NW2d 562 (2003) 28

Salyer Land Co v Tulare Lake Basin Water Storage Dist, 410 US 719, 93 S Ct 1224, 95 L Ed 2d 659 (1973) 32

Sanders v Cantin, No 240065, 2003 Mich App LEXIS 2294 (Sept 16, 2003) 42

Sun Valley Foods Co v Ward, 460 Mich 230, 596 NW2d 119 (1999) 40

The Advisory Opinion Regarding Constitutionality of 1972 PA 294, 389 Mich 441, 208 NW2d 469 (1973) 13, 14

Wilkinson v Lee, 463 Mich. 388, 617 NW2d 305 (2000) 24

Statutes and Rules

MCL 500.3135(1) 4, 13, 39, 40

MCL 500.3135(2) 5

MCL 500.3135(7) ..... *passim*

MCR 2.116(C)(10) 5

Other

RESTATEMENT (SECOND) OF TORTS § 461 24

PROSSER, TORTS § 43 (4th ed 1971) 24

Campbell's Operative Orthopedics (9th ed 1988) 7

Oxford English Dictionary (2d ed 1989) 31

Random House Dictionary of the English Language (unabridged 2d ed 1987) 30

Webster's College Dictionary (1991) 30, 31

Webster's Collegiate Dictionary (10th ed 1997) 7

Webster's II New College Dictionary (2001) 30

Webster's Third New International Dictionary (1964) 30

Webster's Third New International Dictionary (1967) 30

Webster's Third New International Dictionary (1993) 30, 31

INTRODUCTION

Over six years ago, in November 1997, Richard Kreiner ("Plaintiff") was injured in an automobile accident caused by Defendant's negligence. The accident totally destroyed Plaintiff's car, and left him with a painful back injury that has persisted to this day. A central feature of that injury – the disc deterioration and arthritic damage to Plaintiff's back – has been diagnosed as permanent. Other features – including nerve irritation, severe inflammation, and the like – may or may not heal over time. But the bottom line is clear: Plaintiff has suffered a serious injury to his back, and that injury has been objectively verified by medical tests such as x-rays and MRIs, and has been confirmed by the sworn testimony of Plaintiff's doctor.

What is also clear is that Plaintiff's day-in, day-out life has been adversely affected by his injury. Plaintiff has for many years made his living as a carpenter, but the injury has severely restricted his ability to perform his job. Most importantly, the chronic back and leg pain created by his injury requires him to rest frequently, prevents him from working for more than six hours a day — only 75% of his normal day's work. In addition, he cannot safely lift heavy objects – his doctor has recommended that he not lift anything that weighs more than 15 pounds. Nor can Plaintiff safely use ladders or perform roofing work, both of which were regular aspects of his work before the accident.

Over and above these stark limitations on his ability to perform his job as a carpenter, Plaintiff now suffers from back and leg pain throughout his daily life. An injured back is the type of injury that pervades all aspects of one's life: it can make any movement – from walking to bending over to pick up the morning newspaper – a painful endeavor. For example, the injury has restricted Plaintiff's ability to fully engage in his favorite pastime – hunting. While he can

still engage in deer hunting, which requires little movement, he can no longer engage in the more challenging endeavor of rabbit hunting, as that requires that he pursue the game on foot.

Michigan law allows a car accident victim to sue in tort to recover noneconomic damages, such as damages for pain and suffering, where the accident causes a "serious impairment of body function," which has been statutorily defined to mean an objectively manifested impairment to an important body function that affects the plaintiff's general ability to lead his normal life. Here, it is undisputed that Plaintiff has suffered an objectively manifested injury to an important body function. The sole issue is whether that injury affects Plaintiff's "general ability to lead his normal life." The Court of Appeals, reviewing the evidence in the light most favorable to Plaintiffs, held that it does, and reversed the circuit court's order granting summary judgment for Defendant.

Defendant, supported by his amicus, Michigan's largest no-fault automobile insurer ("ACIA"), appeals that ruling, arguing that Plaintiff is unable as a matter of law to satisfy the "general ability to lead his normal life" standard, and therefore should be denied any recovery for his pain and suffering. Central to Defendant's argument is the proposition that Plaintiff's injury simply is not *serious* enough. This argument contradicts this Court's remand order, which makes clear that the impact of the injury on a plaintiff's life need not be "serious" in order for the plaintiff to recover noneconomic damages. Moreover, Defendant's argument is based on a gross misconstruction of the statute: both Defendant and ACIA argue that a court can conclude that a plaintiff's "general ability to lead his normal life" has been "affected" only if it first examines *every* aspect of that plaintiff's life, and finds that *all* (or at least *most*) of those aspects have been affected in some *serious* way.

To illustrate the operation of this standard, ACIA describes a hypothetical set of facts in which a concert violinist is in a Michigan car accident that causes an injury to one of the fingers in his nondominant hand. This injury "effectively ends the violinist's performing career, but only negligibly affects his ability to perform alternative work (e.g., teaching violin), household chores, etc." ACIA Br at 36. According to ACIA, even though this violinist has totally lost the ability to pursue his exceptional vocation, "everyone would intuitively agree that a minor residual impairment of a non-dominant hand does not rise to the level of a serious impairment of a body function." *Id.*

We do not "intuitively agree" with this; to the contrary, we submit that the Michigan Legislature plainly did not intend for this to be the result under such hypothetical facts. In crafting the "general ability" prong of the "serious impairment" definition, the Legislature deliberately specified a *subjective* test: the question is whether the injury affected "*his or her* normal life" – that is, *the plaintiff's* normal life – not the normal life of some abstractly-defined "normal person." No one in this case disputes that. It is therefore inconceivable that the Legislature intended to deny recovery for noneconomic damages to a concert violinist whose performing career is ended by a Michigan car accident, even if that same injury would not have adversely affected the "normal life" of the ordinary or typical person.

We single out this hypothetical because it is unusually revealing as to the nature of the argument being advanced by Defendant and the ACIA. They are not asking this Court to use standard interpretive techniques in discerning the true meaning of the words and phrases used by the Legislature. Instead, they are asking this Court to superimpose onto that statutory text a number of extra-statutory requirements and tests that were not enacted by the Legislature, and that in fact contradict the plain meaning of the statute. They do so as a naked invitation for this

Court to do what the Legislature would not do – essentially, to prevent a plaintiff from bringing suit for noneconomic damages caused by a car accident, unless that plaintiff has suffered a *comprehensive* impairment of his body functions. That is not the standard intended by the Legislature and set forth in the plain text of MCL 500.3135, and this Court should therefore reject the arguments advanced by Defendant and ACIA and affirm the decision of the Court of Appeals.

STATEMENT OF JURISDICTION

Plaintiff-Appellee Richard Adam Kreiner ("Plaintiff") agrees with the statement of jurisdiction of Defendant-Appellant "(Defendant").

COUNTER-STATEMENT OF QUESTION INVOLVED

Whether a back injury that prevents Plaintiff, a carpenter and avid hunter, from working more than 75 percent of his normal work day, from performing particular types of construction work, and from walking or standing on a ladder for more than 20-30 minutes at a time, and that curtails his ability to hunt "affects [Plaintiff's] general ability to lead his . . . normal life," within the meaning of MCL 500.3135(7).

PLAINTIFF answers, "Yes."

DEFENDANT answers, "No."

The Court of Appeals answered, "Yes."

RELEVANT STATUTORY PROVISIONS

MCL 500.3135(1) provides:

> A person remains subject to tort liability for noneconomic loss caused by his or her ownership, maintenance, or use of a motor vehicle only if the injured person has suffered death, serious impairment of body function, or permanent serious disfigurement.

MCL 500.3135(7) provides:

> As used in this section, "serious impairment of body function" means an objectively manifested impairment of an important body function that affects the person's general ability to lead his or her normal life.

STANDARD OF REVIEW

Under MCL 500.3135(2), the issue of whether an injured person has suffered a "serious impairment of body function" is a question of law if the court concludes that there is no material factual dispute regarding the nature and extent of the plaintiff's injuries. Questions of law are reviewed *de novo* on appeal. *Adams Outdoor Adver, Inc v Holland*, 463 Mich 675, 681, 625 NW2d 377 (2001). Furthermore, this Court, in "reviewing orders granting . . . summary disposition . . . must view the evidence in the light most favorable to the nonmoving party." *DiFranco v Pickard*, 427 Mich 32, 38, 398 NW2d 896 (1986). The circuit court granted Defendant's motion for summary disposition under MCR 2.116(C)(10), holding that Plaintiff could not demonstrate a serious impairment of body function.[1] Thus, this Court should exercise *de novo* review of the question whether Plaintiff suffered a "serious impairment of body

[1] Thus, any possible "factual dispute[s] concerning the nature and extent of the [Plaintiff's] injuries" have not yet been submitted to a jury. Nevertheless, in both the Court of Appeals and in this Court, Defendant seeks to inject a factual dispute over the nature and extent of Plaintiff's injuries through reference to a video tape of Plaintiff performing certain work activities on November 4, 1999. See, e.g., Def Br at 6. This tape was not viewed or considered by the trial court. See 58a-59a - 1/24/00 Tr, pp 2-3. Nor did the Court of Appeals consider the video tape, for it directed the circuit court to address the admissibility of this tape on remand, in accordance with its obligation to determine whether there are any genuine issues of material fact regarding the nature and extent of Plaintiff's injury. *Kreiner v Fischer (On Remand)*, 256 Mich App 680, 690, 671 NW2d 95 (2003). For purposes of this appeal, therefore, this Court should consider only the evidence considered by the courts below. Moreover, the video tape does not contradict the evidence submitted by Plaintiff. Defendant suggests that because the video shows Plaintiff performing physical labor, it somehow undermines all of the evidence submitted to demonstrate Plaintiff's injury. Def Br at 6-7. But Plaintiff has never denied that he has continued to work as a carpenter on construction sites. And while the video purports to portray an entire workday in November 1999, it shows that Plaintiff arrived at the construction site at 9:51 am, left the site at 4 p.m., and based on the numerous gaps in the tape's coverage, suggests that Plaintiff was able to work at most five and a half hours throughout the whole day.

function," and must base that review upon the record evidence submitted to the circuit court, viewed in the light most favorable to Plaintiff.

COUNTER-STATEMENT OF FACTS AND PROCEEDINGS

A. Facts.

Plaintiff Richard A. Kreiner was 34 years of age and had worked as a self-employed carpenter and construction worker for over a decade when the automobile accident at issue in this case occurred. See 25a - Kreiner Deposition, pp 3-4; 16a - Dr. Milton examination and report, 9/23/98. On November 28, 1997 Plaintiff crashed his vehicle into Defendant's when the latter pulled out of a driveway without yielding to oncoming traffic. This collision totally destroyed Plaintiff's vehicle, and resulted in injuries that caused plaintiff significant pain in his lower back, right hip, and right leg. See 3b - Complaint ¶¶4-9; 27a-28a - Kreiner Deposition, pp 12-15. Five days after the accident, on December 2, 1997, he was examined by his family physician, Dr. Madhu, who x-rayed Plaintiff and administered cortisone injections in order to alleviate Plaintiff's pain. See 5a - Dr. Madhu notes, 12/2/97; 28a - Kreiner Deposition, pp at 15-16.

Three days later, on December 5, 1997, Plaintiff returned to Dr. Madhu to report that the pain in his lower back, right hip, and right leg was persisting; in addition to administering another cortisone injection, Dr. Madhu prescribed pain and anti-inflammatory medication and referred Plaintiff to physical therapy. See 6a - Dr. Madhu notes, 12/5/97. One week later, Plaintiff returned yet again to Dr. Madhu to report the same pain; once again, Dr. Madhu administered a cortisone injection and prescribed pain and anti-inflammatory medication. See 7a - Dr. Madhu notes, 12/12/97. Plaintiff's pain persisted, and approximately six weeks later, on January 26, 1998, Plaintiff returned to see Dr. Madhu for the fourth time. This time, Dr. Madhu,

in addition to providing limited treatment, referred Plaintiff to Dr. K. Fram, a Board Certified Neurologist and the head of the Neurology Department at Lapeer Community Hospital. See 8a - Dr. Madhu notes, 1/26/98; 36a-37a - Fram Deposition, pp 3-6.

Dr. Fram examined Plaintiff for continuing pain radiating from his right hip to the back of his right leg, particularly in his calf muscle, determining that "EMG and nerve conduction velocity study was abnormal and consistent with mild irritation to the right L4 nerve root (right L4 radiculopathy). Etiology may be related to disc herniation or disc fragment at L4-5." 10a - Dr. Fram office note, 4/13/98. Dr. Fram accordingly prescribed Motrin in order to control the pain and Flexeril for muscle relaxation and instructed Plaintiff to perform certain back and muscle strengthening exercises at home. See *id.* Pursuant to this course of treatment, Plaintiff on April 17, 1998, then underwent an MRI at Lapeer Regional Hospital, which revealed:

> 1. Grade I/II anterior spondylolisthesis of L5 in relation to S1 with bilateral spondylolysis in L5.
>
> 2. Degenerative disc disease at L5-S1 and facet degenerative changes.
>
> 3. Mild degenerative disc disease at L3-L4 and L4-L5.[2]

11a - Lapeer Hospital MRI Report, 4/17/98.

On May 12, 1998, Plaintiff returned to Dr. Fram to complain of pain radiating from the back of his right thigh and right calf, which pain was aggravated by bending over, as well as by either sitting or standing for any length of time. Dr. Fram noted that Plaintiff-Appellee limped on his right foot; had diffuse tenderness in his lumbar spine that was most prominent at his lumbosacral junction; experienced right sciatic leg pain at 60 degrees triggered

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[2] "Spondyolisthesis" is the anterior or posterior slipping or displacement of one vertebrae on another. See *Campbell's Operative Orthopedics* 2952 (9th ed 1988); 43a-44a - Fram Deposition, pp 32-34. "Spondyolysis" refers to arthritic changes involving the vertebrae themselves and how they attach. See 43a - Fram Deposition, p 33. "Facet" refers to a smooth, flat, circumscribed anatomical surface. *Webster's Collegiate Dictionary* 415 (10th ed 1997).

by straight leg raising; and manifested lower back pain secondary to lumbar strain and L4 radiculopathy, degenerative disc disease. Dr. Fram prescribed Ultram for pain control and a continuing program of back and muscle strengthening exercises at home. See 13a - Dr. Fram note, 5/12/98.

Three months later, on August 10, 1998, Plaintiff returned to Dr. Fram and complained of constant lower back pain that was aggravated by climbing, bending over, pushing, and pulling. Once again, Dr. Fram noted that Plaintiff tended to limp on his right foot and further noted: "Back examination was remarkable for mild to moderate stiffness in the lumbar paravertebral muscles at the lumbosacral junction . . . . Straight leg raising triggered low back tenderness at 65 [degrees] on the right side and negative on the left side." 14a - Dr. Fram note, 8/10/98. Following that visit, Plaintiff undertook three weeks of physical therapy. See 29a - Kreiner Deposition, pp 18-19.

On October 9, 1998 (almost a year after the accident), Plaintiff saw Dr. Fram for a follow-up evaluation, reporting that the physical therapy had not alleviated the pain, and, if anything, had exacerbated it. Dr. Fram's examination revealed "tenderness and mild stiffness in the lumbar paravertebral muscles more prominent at the lumbosacral junction. Straight leg raising triggered lower back pain and right hip pain at 45 [degrees] on the right side and negative on the left side." Dr. Fram prescribed Relafen and recommended that Plaintiff continue his program of home exercises. See 15a - Dr. Fram note, 10/9/98.

Once Plaintiff's No-Fault benefits terminated, he could no longer afford, and thus discontinued, his medical treatment and use of prescription medications. See 29a - Kreiner Deposition, pp 19-20. Even so, Plaintiff returned to see Dr. Fram in August of 1999. According to Dr. Fram's notes from that visit:

> Mr. Kreiner was seen on follow up visit because of continuous complaints of lower back pain with most of the pain localized to the right side, right leg pain mostly localized to the hip. Mr. Kreiner report pain radiation to the right lower extremity mainly to the right thigh and back of the leg. The pain was aggravated by standing on his feet for any length of time, lifting, climbing a ladder, staying in one position for a long period of time.

And upon examination, Dr. Fram noted that:

> Back examination was remarkable for mild tenderness and stiffness in the lumbar paravertebral muscles. Straight leg raising triggered low back tenderness at 50 degrees on the right side and negative on the left side.
>
> . . . .
>
> MRI examination of the lumbar spine from 8-17-99[3] showed degenerative disc disease at L3-S1 and grade I/II anterior spondylolisthesis of L5 in relation to S1.

34a - Dr. Fram note, 8/6/99. Dr. Fram advised Plaintiff, in addition to continuing his home exercise regimen, to use a back support garment during daily activity, to avoid lifting over 15 pounds, and to refrain from excessive bending and twisting; he also prescribed Skelaxin. See *id.*

Before the accident, Plaintiff made his living doing general carpentry and construction work, including "remodeling, decks, a little bit of everything; roofing, siding, stuff like that." 25a - Kreiner Deposition, pp 4-5. He was also an avid hunter whose game of choice was rabbit and deer. See 30a, 32a – Kreiner Deposition, pp 22, 32-33. As the Court of Appeals explained in its initial decision and reiterated upon remand, however, Plaintiff's life has been demonstrably and adversely impacted by his condition.

> The plaintiff's deposition testimony indicated that, after the accident, he continued to work as a carpenter, which forced him to perform some tasks that were painful, and the pain limited his time to work on a project. Plaintiff stated that he could no longer work eight hours a day but rather is limited to six hours a day, that he can no longer do roofing work, that he can only do ladder work for twenty minutes at a time, that he cannot lift more than eighty pounds, that he

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[3] Plaintiff agrees with Defendant that this reference to " '8/17/99' apparently is a typographical error and should have identified the date of the MRI as April 17, 1998." Def Br 4 n 2.

> cannot walk more than one-half mile, and that he can no longer participate in certain types of recreational hunting.

Kreiner v Fischer (On Remand), 256 Mich App 680, 687, 671 NW2d 95 (2003).

B. Proceedings.

Plaintiff initially filed suit on October 5, 1998, alleging that Defendant's negligence in causing the accident was the proximate cause of Plaintiff's injuries. See 2b-7b - Complaint. Circuit Judge Holowka granted summary judgment in favor of Defendant on the ground that "the claimed injury is not serious" and that the resulting "impairment is [not] serious enough to have impinged on his ability to lead a normal life." Judge Holowka thus concluded "that as a matter of law the impairments [from] which Plaintiff claims he suffers . . . do not impinge in any real sense [o]n his ability to lead a normal life. Therefore, he is not entitled to maintain this action in tort against Defendant under the No-Fault Statute, MCL 500.3135(1)." 65a-67a - 1/24/00 Tr, pp 9-11.

On May 31, 2002, the Court of Appeals reversed Judge Holowka. Judge Murphy, writing for a unanimous panel, held that Judge Holowka erred in "rul[ing] that as a matter of law the impairment was not 'serious enough' to impinge on plaintiff's ability to lead a normal life . . . . The third prong of the statutory definition explicitly requires only that the impairment 'affect[] the person's general ability to lead his or her normal life.' . . . . It would be improper for us to read any more requirements, limitations, or language into the unambiguous statutory definition." *Kreiner v Fischer*, 251 Mich App 513, 518, 651 NW2d 433 (2002), *vacated and remanded*, 468 Mich 884, 661 NW2d 234 (2003) (citations omitted). Assuming that the facts relating to Plaintiff's physical limitations were not in dispute, the Court of Appeals "would find that they satisfy the third prong of the statutory definition, and plaintiff would be entitled to summary disposition on the issue whether he suffered a serious impairment of body function pursuant to

MCL 500.3135(2)(a)(i), contrary to the trial court's ruling." *Id.* at 519. The Court of Appeals nonetheless remanded with instructions for the trial court to "determine whether there are material issues of fact regarding plaintiff's claims relative to the effect of the injury on his ability to work" and, in so doing, to "consider the admissibility of the videotape offered by defendant [purporting to depict Plaintiff performing his ordinary activities]," which the trial court had yet to review. *Id.*

Defendant then filed an application for leave to appeal to this Court. The Court granted the application on April 9, 2003,[4] vacated the decision of the Court of Appeals, and remanded for further proceedings. The Court stated:

> In our judgment, both the circuit court and the Court of Appeals erred. Although a *serious* effect [on plaintiff's ability to lead his or her normal life] is not required, *any* effect does not suffice either. Instead, the effect must be on one's *general* ability to lead his normal life. Because we believe that neither of the lower courts accurately addressed this issue, we remand this case to the Court of Appeals for it to consider whether plaintiff's impairment affects his general ability to lead his normal life.

Kreiner v Fischer, 468 Mich 884, 661 NW2d 234 (2003).

Following this Court's remand, the Court of Appeals confirmed that it had contemplated and conducted in its earlier opinion the very inquiry prescribed by this Court. It accordingly amended its prior opinion to make clear that "*any* effect does not suffice to establish a serious impairment of body function under MCL 500.3135, rather the effect must relate to a person's general ability to lead his or her normal life." 256 Mich App at 687. And it explained that the operative inquiry was satisfied in this case because of both the qualitative and quantitative implications of the injury suffered by Plaintiff in light of his demonstrated circumstances – that

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[4] Justice Kelly would have denied leave to appeal. See 468 Mich 884 (2003).

is, the effect of the injury on his normal life as a professional carpenter and avid hunter, and the extent to which those and other aspects of his normal life have been sharply curtailed.

> We find that one's general ability to lead his or her normal life can be affected by an injury that impacts the person's ability to work at a job, where the job plays a significant role in that individual's normal life, such as in the case at bar. Employment or one's livelihood, for a vast majority of people, constitutes an extremely important and major part of a person's life . . . . An injury affecting one's employment and ability to work, under the right factual circumstances, can be equated to affecting the person's *general* ability to lead his or her normal life.
>
> . . . .
>
> Here, there was documentary evidence presented by plaintiff that his ability to walk, undertake certain physical movements, and engage in recreational hunting was limited by the injury. These limitations along with plaintiff's alleged employment limitations, if true, indicate that plaintiff suffered a serious impairment of body function under § 3135.
>
> [T]here was documentary evidence presented indicating that plaintiff's ability to work a full eight-hour day was reduced by twenty-five percent, that he could no longer do roofing jobs, that ladder work was limited, and that there were weight and movement restrictions. These limitations, if proved, are significant enough to support a finding that plaintiff's impairment affected his general ability to lead his normal life.

Id. at 688-90; see also *id.* at 687-88 & n 6. The Court of Appeals therefore "[r]eversed and remanded for proceedings consistent with [its] opinion." *Id.* at 690.

Defendant timely applied for leave to appeal to this Court; the application was granted on November 6, 2003.

LEGISLATIVE AND JUDICIAL BACKGROUND

In 1972, Michigan's Legislature passed the No-Fault Automobile Insurance Act, MCL 500.3101 et seq., which became effective in October of 1973, making Michigan one of approximately fourteen States in the Nation to have adopted a system of no-fault automobile insurance. Under the basic scheme, a victim of an automobile accident generally has the right to recover four types of prescribed benefits from Michigan's no-fault regime: (i) unlimited lifetime

medical and rehabilitation expenses payable for life ("allowable expenses"); (ii) limited wage loss benefits payable for three years; (iii) limited domestic replacement services payable for three years; and (iv) limited survivor's loss benefits payable for three years. All of these benefits are payable without regard to fault. A victim can recover damages beyond those prescribed under the no-fault system only through tort. Claims for excess "economic loss" may in all events be pursued in tort. Claims for "noneconomic loss," however, such as pain and suffering, incapacity, loss of function, loss of consortium, etc., may be pursued in tort *only if* a victim first satisfies the statutory threshold set forth in Section 3135 of the Act (MCL 500.3135(1)): "A person remains subject to tort liability for noneconomic loss caused by his or her ownership, maintenance, or use of a motor vehicle only if the injured person has suffered death, serious impairment of body function, or permanent serious disfigurement."

In 1973, this Court rendered *The Advisory Opinion Regarding Constitutionality of 1972 PA 294*, 389 Mich 441, 208 NW2d 469 (1973), upholding the constitutionality of Michigan's no-fault system. In doing so, it specifically addressed the threshold determination contemplated by the statute.

> The final question is whether the phrases "serious impairment of body function" and "permanent serious disfigurement" provide standards sufficient for legal interpretation.
>
> This Court holds that such phrases are capable of legal interpretation and, indeed, that juries or judges sitting without juries frequently have to and do interpret comparable phrases bearing upon various facets of the law. Such findings result from denominated fact questions and thus are within the exclusive province of the triers of fact. Only when interpretation approaches or breaches permissible limits does it become a question of law for the Court. Such questions must be approached on a case by case basis.
>
> . . . .
>
> Clearly the subject phrases "serious impairment of body function" and "permanent serious disfigurement" as used in § 3135 of this act are comprised of

> no less commonly used or understood words of the English language, nor is the language presently before the Court less precise than that which has been adopted to express other standards for determining tort liability. The phrases are within the province of the trier of fact and are sufficient for legal interpretation.

Id. at 477-81.

The Court substantially altered course nearly a decade later in *Cassidy v McGovern*, 415 Mich 483, 330 NW2d 22 (1982), simultaneously limiting the jury's role in determining whether the statutory threshold of Section 3135 had been surmounted in a particular case and raising the substantive threshold. Thus, the Court held that the question whether a plaintiff had cleared the threshold was to be treated as a matter of statutory construction for the court, absent a material "factual dispute as to the nature and extent of a plaintiff's injuries." *Id.* at 502. The Court also held that the statutory phrase "serious impairment of body function" entailed multiple independent requirements: (i) impairment of an "important body function[]," *id.* at 505; (ii) injuries that have an "effect . . . on the person's general ability to live a normal life," *id.* at 505; (iii) "objectively manifested injuries," *id.* at 505; and (iv) injuries otherwise qualifying as "sufficiently serious" in light of such things as their permanence (which could be significant to the inquiry, though not a hard-and-fast requirement). *Id.* at 505.

Four years later, in *DiFranco v Pickard*, 427 Mich 32 (1986), the Court effectively repudiated *Cassidy*. First, as to the jury's role, it returned to the *Advisory Opinion* in holding that, "[i]f reasonable minds can differ as to whether the plaintiff suffered a serious impairment of body function, the issue must be submitted to the jury, even if the evidentiary facts are undisputed." *Id.* at 58. Second, it left the requirement that an injury be objectively manifested intact, but clarified that the injury need only be "medically identifiable" and have some "physical basis" in order to so qualify. *Id.* at 74-75. Third, it rejected the notion of an "important body function," which it described as "judicially engrafted" by *Cassidy*, while recognizing that certain

injuries would in particular cases be adjudged too "trivial" to permit recovery. *Id.* at 61-62. Fourth, it likewise rejected the notion that an injury must affect a victim's "general ability to lead a normal life," which had in practice "proved to be an almost insurmountable obstacle" to recovery in tort. *Id.* at 62-67. Finally, it stated that " '[t]he 'serious impairment of body function' threshold is a significant, but not extraordinarily high threshold" intended simply "to eliminate suits based on clearly minor injuries, and those injuries which did not seriously affect the ability of the body, in whole or in part, to function." *Id.* at 59-60.

Subsequent to *DiFranco*, two ballot questions concerning the operative statutory threshold were proposed and defeated. The first of these, Proposal D, went on the ballot in Michigan in November 1992 and would have effected a return to the *Cassidy* regime, at least in relevant part, by requiring that a victim suffer "an objectively manifested impairment of an important body function that affects his or her general ability to lead *a normal life*." Addendum 2 - Proposal D, Ballot Question in Michigan's 1992 General Election (emphasis added). It was defeated. The second, Proposal C, went on the ballot and contained language much more comparable to that currently in the statute, requiring that a victim suffer "an objectively manifested impairment of an important body function that affects his or her general ability to lead *his or her normal life*." Addendum 3 - Proposal C, Ballot Question in Michigan's 1994 General Election (emphasis added). It too was defeated.

In 1995, Michigan's Legislature amended the no-fault system in several significant respects. One amendment provided an explicit definition for the phrase "serious impairment of a body function":

> As used in this section, "serious impairment of body function" means an objectively manifested impairment of an important body function that affects the person's general ability to lead his or her normal life.

MCL 500.3135(7). This definition is commonly understood to impose three distinct requirements: the impairment must (a) be objectively manifested; (b) be of an important body function, and (c) affect the person's general ability to lead his or her normal life.

This case boils down to the question of how the third of these prongs should be interpreted. The trial court believed it could only be satisfied by "sufficiently serious" injuries. The Court of Appeals reversed, ruling that there was no independent "seriousness" requirement in the "general ability to lead his normal life" standard. This Court agreed with that conclusion, but also held that the Court of Appeals had itself erred in failing to articulate how the "general ability" prong requires more than merely *any* effect on the plaintiff's normal life in order to be satisfied. Accordingly, on remand, the Court of Appeals elaborated upon the significance of the "general ability" standard, and clarified that it was not holding that "any" effect would satisfy that standard.

SUMMARY OF ARGUMENT

1. When the Michigan Legislature enacted Section 3135(7), it specifically rejected a no-fault tort threshold that utilized an objective life impact test, and instead opted to utilize a subjective life impact standard that focuses the inquiry on whether the normal life *of the injured plaintiff* was, in some way, affected by the injury.

2. The Legislature's decision to use a subjective life impact test is a specific repudiation of the "almost insurmountable" *Cassidy* objective life impact test, as well as the *DiFranco* Court's holding that prohibited the use of any life impact test.

3. The interpretation of Section 3135(7) advocated by Defendant is nothing more than a thinly veiled invitation for this Court, despite the Legislature's clear decision to the contrary, to engraft an objective life impact test onto an otherwise unambiguous statute.

4. The Legislature's use of the phrase "*general ability*" neither negates the foregoing conclusions nor imports into Section 3135(7) a requirement that the effect of the impairment on the plaintiff's life be "serious." The commonly accepted dictionary definition of the phrase "*general ability*" is simply "*ability*." The phrase "general ability" makes clear that the statute is referring to a singular, indivisible "ability," which is comprised of countless specific "abilities," to lead one's "normal life." And if the plaintiff's "general ability" is adversely affected in any of its particulars by an impairment, it is not the same "general ability" that it was before the injury.

5. Section 3135(7) limits claims for noneconomic loss by utilizing a standard that considers only the impairment's effect on plaintiff's "*normal life*," as opposed to a standard that would consider any *de minimis* change in *any* aspect of the plaintiff's life writ large.

6. This Court recognized the correctness of the foregoing analysis when it ruled, in its prior remand order in this case, that Section 3135(7) does not require proof of an injury that "*seriously affects*" the plaintiffs' ability to lead his normal life.

7. In the case at bar, the evidence, which must be viewed in the light most favorable to Plaintiff, clearly shows that Plaintiff Kreiner's ability to live his normal life was demonstrably adversely affected by the impairment caused by his injury.

ARGUMENT

Defendant argues that "the plain meaning of the word 'general' provides the basis for [the] distinction" between "a truly '*serious*' impairment" and one that does not deserve to satisfy the no-fault threshold for bringing suit for noneconomic damages. Def Br at 27. That is not correct. The courts that have interpreted Section 3135(7)'s use of the phrase "general ability," and the courts that interpreted the *Cassidy* decision's use of that same phrase, have not relied upon it as imposing a **special** burden on plaintiffs seeking to satisfy the "serious impairment"

threshold. Rather, a plaintiff must show only that the impairment "affects" his or her "normal life" – that is, the impairment must actually have a "life-altering" impact, in that the plaintiff's "normal life" prior to the accident has been demonstrably adversely impacted in some way.

Because this a fundamental point that must be understood at the outset, we devote Section I of the argument below to an elucidation of the context in which Section 3135(7) was enacted, and the relevance of the "normal life" inquiry. In Section II, we respond to all of Defendant's and ACIA's arguments regarding the alleged significance of the word "general," and demonstrate that the phrase "general ability" can only operate to *lower* the threshold plaintiffs must satisfy. We also rebut in Section II Defendant's and ACIA's invitation to this Court to create additional, extra-statutory tests designed to ensure that the impairment at issue is sufficiently "serious." Finally, in Section III, we analyze the Court of Appeals' decision on remand, and demonstrate that it is wholly consistent with the governing law.

Beyond the arguments set forth below, however, it is important to emphasize one overarching point. Much of the skirmishing between Defendant and Plaintiff before this Court revolves around the appropriateness of using certain words or semantic formulations to articulate the proper legal standards to be applied in this and similar cases. While it is undoubtedly important for this Court to resolve those skirmishes, it is worth recognizing at the outset that no abstract formulation of a legal standard, no matter how detailed or carefully worded, can possibly provide an unambiguous answer to inherently fact-specific, circumstantial determinations that necessarily require *ad hoc* resolution on a case-by-case basis. Even if resolved by courts as "a matter of law," the question whether an injury constitutes a "serious impairment of a body function" will always involve case-specific judgments that are extremely difficult, if not impossible, to capture in an abstract legal formula.

For that reason, we submit that in analyzing the competing statutory arguments, it is vitally important that the Court keep in mind that the evidence in this particular case must be viewed in the light most favorable to Plaintiff. The most important of these facts can be summarized as follows: Defendant's negligence caused Plaintiff to suffer an objectively manifested back injury causing chronic pain in his lower back, right hip, and right leg; the existence of this persistent pain has been particularly restrictive for Plaintiff because he is employed as a carpenter and construction worker, and therefore is required to be on his feet and physically active in order to do his job; indeed, Plaintiff's ability to engage in his vocation has been substantially impaired, to the point where he is only able to perform 75% of his normal work day; similarly, Plaintiff has also suffered a diminishment in his ability to engage in his favorite pastime and other basic activities. Under these facts, it simply does not matter what judicial gloss is read onto the plain text of the statute: it simply cannot be denied that Plaintiff's injury "affects his general ability to lead his normal life." The only way to reach a contrary conclusion would be to rewrite the statute itself. And that is precisely what Defendant urges this Court to do.

I. UNDER THE 1995 AMENDMENTS, A PLAINTIFF WHO DEMONSTRATES THAT AN IMPAIRMENT HAD AN EFFECT ON HIS NORMAL LIFE SATISFIES THE THRESHOLD TO SUE IN TORT

This Court's remand order stated that "[a]lthough a *serious* effect is not required, *any* effect does not suffice either. Instead, the effect must be on one's *general* ability to lead his normal life." 468 Mich 884. Not surprisingly, the Court of Appeals on remand and Defendant on this appeal focus on the meaning of "general" as holding the key to the outcome of the case. We submit that before addressing the meaning of "general," it is critical first to read the entire provision at issue, and to understand the context of its 1995 amendment. For in doing so, it

becomes clear that the statute's reference to the plaintiff's "normal life" is of far greater significance in determining the nature of the statutory tort liability threshold than is the phrase "general ability."

The Legislature amended Section 3135 in order to alter the regime established in *DiFranco v Pickard*, 427 Mich 32 (1986), and to ensure appropriate control over the number and nature of tort suits for noneconomic loss. In so doing, the Legislature very clearly and precisely modified the no-fault tort mechanism in five important respects. First, it authorized courts, rather than juries, to resolve threshold questions, apart from material "factual dispute[s] concerning the nature and extent of the [plaintiff's] injuries." Second, it categorically foreclosed recovery of noneconomic loss by "a party who is more than 50% at fault." Third, it likewise foreclosed recovery of noneconomic losses by a plaintiff who was the owner of an uninsured vehicle. Fourth, it provided a specific definition for "serious impairment of a body function," and in that definition it added the requirement that the impairment be to "an important body function," a requirement which *DiFranco* had rejected. Fifth, it also included in the definition of "serious impairment of a body function" the *subjective* requirement that the impairment "affect the person's general ability to lead *his or her* normal life," which also was a requirement that *DiFranco* had rejected.

Only the import of the fifth modification is at issue here. It is not in controversy that the Legislature in Section 3135 disqualified two categories of plaintiffs (owners of uninsured vehicles and those more than 50% negligent) from recovering noneconomic damages for "serious impairment of body function," altered the procedure by which such claims would be resolved (increasing the judge's role versus that of the jury) so as to streamline litigation and aid predictable resolution of it, and amended the substantive threshold to require that an injury

involve "an important body function." These changes, on their own, serve to fulfill the purposes of the legislation as outlined in the legislative history quoted by Defendant. Def Br 26 (citing 54a-55a - House Legislative Analysis Section, HB 4341 as enrolled, 1995 PA 222 (12/18/95), p 2).

But the legislative history of Section 3135(7) states clearly that the Legislature intended to "weed out" only what it called "*undeserving* and *frivolous* cases." 54a - House Legislative Analysis Section, HB 4341 as enrolled, 1995 PA 222 (12/18/95), p 2 (emphases added). Consistent with this purpose, when the Legislature considered the "general ability" inquiry, it explicitly refused to return to the substantive threshold established in *Cassidy*, which had looked "to the effect of an injury on the person's ability to live *a* normal life." 415 Mich at 505 (emphasis added). In other words, the *Cassidy* standard used an objective standard – the typical "normal life" – to measure whether each particular plaintiff satisfied the inquiry. Emphasizing that "there is no such thing as 'a normal life,' " the *DiFranco* Court rightly described the *objective* standard as "an almost insurmountable obstacle" that could be overcome "only [by] plaintiffs who are bedridden, cannot care for themselves, or are unable to perform any type of work." 427 Mich at 66.[5] Indeed, the Court decried a standard that is indifferent to the plaintiff's

[5] See, e.g., *DiFranco*, 427 Mich at 66 (describing *Cassidy* standard as allowing recovery only to "plaintiffs who are bedridden, cannot care for themselves, or are unable to perform any type of work"); *Franz v Woods*, 145 Mich App 169, 177, 377 NW2d 373 (1985) (holding that a young, physically active woman who incurred back and neck injuries causing muscle spasms, occasional numbness in her arm and shooting pain in her leg, and chronic pain in her back, lower back, and shoulders could not recover because: "While Plaintiff's testimony indicates a significant change in *her normal life* style – an athletic, outdoors one – we believe that she has the general ability to live what can objectively be termed *a normal life*.") (emphases added); see also *Owens v Detroit*, 163 Mich App 134, 136-38, 413 NW2d 679 (1987) (acknowledging that plaintiff – "who received approximately fifty stitches in the area of his eye immediately after the collision," resulting in "internal scarring" that caused "the eye . . . to droop and water some five years after the accident," and who also broke "four front teeth" that "ultimately had to be removed" and

individual circumstances because it "bars recovery of noneconomic damages for minor injuries regardless of how seriously the injury affects a particular person's life."

As the ACIA concedes, the Legislature was "cognizant" of the *DiFranco* Court's pointed criticism of *Cassidy's* objective standard and made a "notable" decision to "instead require[] that the impairment affect 'the person's general ability to lead his or her normal life.' " ACIA Br 32-33. This substitution of a subjective inquiry into the particular plaintiff's normal life was therefore intended to be, and was, a very significant relaxation of the threshold applied during the *Cassidy* era.

To be sure, the *DiFranco* Court rejected the use of *any* "normal life" inquiry, whether objective or subjective. Indeed, in the course of criticizing a subjective "normal life" test, the *DiFranco* Court expressed the view that "[f]ocusing on the effect an injury has on a particular person's life can lead to anomalous results." 427 Mich at 65. Specifically, the Court analyzed the difference between two hypothetical injuries involving a concert violinist: in one, the violinist suffers leg injuries that confine him to his wheelchair for life, but allow him to continue performing concerts; in the other, the injury is to his little finger, and the resulting impairment effectively ruins his performing career. *Id.* at 65-66. The Court concluded that there was no "normal life" test which could adequately deal with both hypotheticals, since a subjective test "could reward the malingerer or hypochondriac, while penalizing the person who cannot afford to miss work or tries to function despite the pain," whereas the objective test is "equally flawed" because "[d]etermining which activities are essential to living a normal life is an . . . impossible task." *Id.* at 66.

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replaced "with a partial plate" that caused "trouble talking and eating" – would *not* have been entitled under *Cassidy* to recover for a "serious impairment of body function").

Notwithstanding this reasoning from the *DiFranco* Court, the Legislature chose to enact a *subjective* "normal life" test. In doing so, it clearly accepted *DiFranco*'s criticisms of the objective test while *rejecting* its criticisms of the subjective test. Accordingly, the 1995 amendments must be understood as adopting the following indictment in *DiFranco* of the *Cassidy* Court's objective test:

> The most obvious problem is defining what constitutes "a normal life." The Court of Appeals has never attempted to define the phrase, since it usually concludes that the injuries sustained did not significantly affect the plaintiff's life style or daily activities. However, *relief has been denied where the injuries did significantly affect the plaintiff's normal life style and activities.*
>
> The Court of Appeals has repeatedly stated that *mere difficulty in performing activities is not sufficient to establish a serious impairment of body function.* In denying relief, panels often note that the plaintiff was not "incapacitated" or "confined to bed." *Short shrift is usually given to the fact that the plaintiff is no longer able to engage in the recreational activities he previously enjoyed. However, if the plaintiff can still perform such activities, this indicates that he is able to live a normal life.*
>
> If the plaintiff eventually returned to work, even after an absence of several months, the Court of Appeals has usually concluded that there has been no significant interference with the plaintiff's normal life. *This is true even if permanent medical restrictions have been placed on plaintiff's ability to lift or perform certain types of work.* Restrictions imposed by the plaintiff, rather than his doctor, are usually ignored. Relief has generally been denied to plaintiffs who eventually regained their full range of motion, even if the initial limitation was significant.
>
> In short, the Court of Appeals has strictly applied the "general ability to live a normal life" test. *If the plaintiff can perform common day-to-day activities, albeit with some difficulty, or can eventually return to work, the plaintiff is usually deemed not to have suffered a serious impairment of body function. The bottom line is that few plaintiffs have been given the opportunity to recover noneconomic damages since* Cassidy *was decided.*

Id. at 62-65 (emphases added).

As this passage helps illustrate, in the *Cassidy* era the hypothetical "normal life" standard had created a rigid and "almost insurmountable" barrier to recovery of noneconomic damages.

Even though the phrase "general ability" originated in *Cassidy* and was repeated by Cassidy's progeny, none of the cases decided under that standard relied upon that phrase in barring plaintiffs from pursuing their remedies in tort. It was the definition of "normal," not the definition of "general," that put the teeth into the *Cassidy* test. So too under the subjective version of the "normal life" standard enacted by the Legislature; the focus of the inquiry should be on the question whether Plaintiff's "normal life" has been affected, and not on what constitutes that Plaintiff's "general ability" to live his normal life.

Unlike the *Cassidy* objective test, the subjective test enacted by the Legislature is anchored in a concrete, demonstrable reality: the *actual* life lived by the *actual* plaintiff before the Court – both before and after the accident in question.[6] That is the "altered lifestyle" analysis that Defendant and ACIA urge the Court to reject, yet it is this case-specific analysis, not Defendant's "non-exhaustive factors" or the ACIA's "six rules of law," that will provide a manageable "decisional framework" for lower courts. For example, this subjective "normal life" standard would allow the concert violinist to recover noneconomic damages for a career-ending injury to his finger, but would deny any tort recovery to the others who suffer the same injury, but whose "normal lives" are not altered by it. Defendant and ACIA resist this straightforward rule of law because they seek to reinject the very sort of vagaries and arbitrary grounds for exclusion that were associated with the *Cassidy* regime, and from which the Legislature deliberately departed in 1995. They seek to inject these vagaries through the phrase "general

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[6] It bears noting that this subjective test is also anchored in basic precepts of tort law, according to which a tortfeasor must take his victim as he finds him, inclusive of any special characteristics or circumstances that may make that victim especially susceptible to injury and resulting harm. See PROSSER, TORTS § 43, at 261-62 (4th ed 1971); RESTATEMENT (SECOND) OF TORTS § 461. As this is likewise an established principle of the law of torts in Michigan, see e.g., *Wilkinson v Lee*, 463 Mich. 388, 396-97, 617 NW2d 305 (2000), it is only natural and proper that the Legislature would have incorporated it into the operative tort threshold in the form of a subjective conception of the particular plaintiff's normal life.

ability" rather than through the "a normal life" test, but the thrust of their efforts is unmistakable: to achieve through judicial fiat what could not be achieved through the legislative process or popular vote.[7]

Again, ACIA provides the plainest illustration of the extremes to which a return to *Cassidy* might lead. ACIA returns to the *DiFranco* Court's hypothetical of the concert violinist who "injures his non-dominant hand in an auto accident" such that he suffers "permanent loss of some dexterity and strength in the hand" that "effectively ends [his] performing career." ACIA Br 35-36. According to ACIA, then, Itzak Perlman should be denied recovery for noneconomic losses because such an injury would not affect his "general ability to lead . . . his normal life." ACIA Br 35-36, 40. ACIA assures us that, much as the injury has wholly precluded Itzak Perlman from continuing the vocation that singularly defined *his* normal life, he is still able to perform "all basic human functions."[8] And although he tragically suffered "the premature termination of his performing career," he must nonetheless be limited to recovering only his economic losses. *Id.* at 40.

This is precisely the result decried in *DiFranco* and which the Legislature chose to reject in enacting the subjective test in 1995. It is hard to fathom a plaintiff whose noneconomic damages – whose pain and suffering and emotional distress – could be more compelling than would be Mr. Perlman's should such a tragedy befall him. The Legislature did not "intuitively agree," ACIA Br 36, with ACIA's judgment that this plaintiff should not recover despite the

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[7] Indeed, as previously noted, *supra* at 15-16, the electorate has defeated the *Cassidy* standard twice: first, a ballot question proposing substantively equivalent language regarding "general ability to lead *a* normal life" was convincingly rejected by the voters in a 1992 ballot initiative; second, the Legislature in 1995 modified that language in a deliberate rejection of *Cassidy*'s objective standard. Addendum 2 (emphasis added).

[8] Defendant's notion that some undefined set of "basic human functions" common to us all must be impacted in order to permit recovery by a particular plaintiff is of course eerily reminiscent of the objective understanding of "a normal life" that the Legislature has expressly rejected.

seismic effect of the impairment on an activity at the very core of "his normal life," simply because he can still do *other* things that *other* people do in life. That is precisely why the Legislature abandoned the objective test of *Cassidy*. To hold otherwise would throw Michigan's no-fault system decidedly out of balance by denying recovery to "deserving" plaintiffs whose automobile injuries result in significant noneconomic losses that, while beyond adequate recompense, are only compensable through the tort system.

Defendant and ACIA clearly seek a return to the *Cassidy* era in which plaintiffs were faced with an "almost insurmountable" obstacle in seeking tort remedies for enormous pain, suffering, and emotional distress caused by automobile injuries that profoundly altered their lives. Equally clear is that the Legislature specifically rejected this harsh result when it enacted the subjective "normal life" inquiry; it therefore did not intend for this Court to recreate this standard through the phrase "general ability."

II. THE LEGISLATURE DID NOT INTEND THE WORD "GENERAL" TO IMPOSE A SECOND SERIOUSNESS REQUIREMENT

Defendant states that "[t]he precise question of statutory interpretation presented in this case concerns the meaning of [the word] 'general' as it is used to modify the word 'ability.' " Def Br at 23. But Defendant immediately follows this statement with the assertion that the "manifest intent" of the Legislature is that "the word 'serious' is a critical part . . . of the statute at issue." Def Br at 24. This is then followed by four pages of argumentation as to the existence of an independent "seriousness" requirement that must be read into the "general ability" inquiry. See Def Br at 24-28. Thus, before Defendant even bothers to reference the dictionary definition of "general," he asserts that "the plain meaning of the word 'general' provides the basis for [the] distinction" between "a truly '*serious*' impairment" and one that does not deserve to satisfy the no-fault threshold for bringing suit for noneconomic damages. Def Br at 27. Based on this

reasoning, both Defendant and the ACIA argue that this Court should engraft a number of additional tests onto the "general ability" prong, in order to provide a "decisional framework" that will allow only "serious effects" on the plaintiff's normal life to satisfy the threshold.

There are at least four reasons why Defendant's argument must be rejected. First and foremost, Defendant fails to provide a coherent definition of the phrase "general ability" that comports with the requirement that this Court give effect to the plain meaning of the statutory text enacted by the Legislature. When properly understood, this phrase indicates an *unlimited* and *unqualified* conception of the plaintiff's "ability to lead his normal life," which is impacted if the plaintiff's ability is *limited* or *qualified* in any way. Second, Defendant's argument that a court must separately analyze *all* aspects of a plaintiff's "normal life" before determining whether that plaintiff satisfies the "general ability" test is entirely wrongheaded: not only is it completely impractical, but this understanding of the "general ability" prong would lead to absurd results. Third, this Court has already rejected the proposition that there must be a "serious effect" on a plaintiff's general ability to lead his normal life. Finally, the suggestion that this Court should create an additional "decisional framework" of "non-exhaustive factors" that must be considered over and above the test actually enacted by the Legislature is nothing more than a transparent attempt to close the courts to all but incapacitated plaintiffs: the Legislature has already enacted a three-part test, and this Court should not engraft an extra-statutory, multi-factored test on top of it.

A. The Phrase "General Ability" Simply Refers To A Singular And Unqualified "Ability"

Plaintiff readily agrees with Defendant, and with the court below, on how statutory construction must proceed: "the '*foremost* rule of statutory construction [is that] courts are to effect the intent of the Legislature.' " Def Br 23 (citation omitted). Furthermore, in order

properly to construe the intent of the Legislature, it should be assumed that the Legislature meant to adopt the "plain meaning" of the words and phrases it enacted. See, e.g., *Parkwood Ltd Dividend Hous Ass'n v State House Dev Auth*, 468 Mich 763, 772, 664 NW2d 185 (2003) (internal citations omitted) ("In resolving [an] issue of statutory interpretation, our primary aim is to effect the intent of the Legislature. First, we examine the language of the statute. 'If the statute's language is clear and unambiguous, we assume that the Legislature intended its plain meaning, and we enforce the statute as written.' ") (internal citations omitted).

But while Defendant mouths the principle that the "plain meaning" intended by the Legislature should govern, it makes precious little effort to identify that plain meaning. Most tellingly, Defendant makes no reference to the definition of the very phrase that is at issue here – "general ability" – which is independently defined in Webster's Third New International Dictionary[9] as follows:

"**general ability** *n*: ABILITY."

Thus, according to Webster's Third, the phrase "general ability" means simply "ability." While this may appear at first blush to contradict the established doctrine that no words should be construed to be redundant or without meaning, it does not do so. The adjective "general" helps to modify the particular meaning of the word "ability" that is intended. Although Defendant does not define the word "ability," his *amicus* provides a multi-part definition that includes "the quality or state of being able," the "physical, mental, or legal power to perform," as well as "competence . . . capacity, fitness, or tendency to act or be acted on in a (specified) way." ACIA Br 36 (quotations and citations omitted). This definition confirms the common sense

[9] This Court has often relied upon Webster's Third to elucidate the plain meaning of statutory terms. See *Lytle v Malady*, 458 Mich 153, 165 n 11, 579 NW2d 906 (1998); *Rednour v Hastings Mut Ins Co*, 468 Mich 241, 248, 661 NW2d 562 (2003); *Hanson v Mecosta Co Rd Comm'rs*, 465 Mich 492, 502, 638 NW2d 396 (2002).

understanding of the various ways in which the word "ability" can be used. Consider for example the following sentences:

- X has the ability to breathe;
- Y has the ability to play the violin;
- Z has the ability to write a legal brief.

All three of these sentences employ slightly different understandings of the word "ability," each corresponding to slightly different aspects of the dictionary definition of "ability." The first is purely physical and states an objective fact; the second is both physical and mental, and states a fact that involves subjective judgment; the third is physical, mental, and legal, and states an opinion that involves subjective judgment. But one way in which all three are similar is that they refer to the specific ability to do one, specific thing. By contrast, a person's "ability to live his normal life" is quite different. It does not refer to a *specific* ability to do a *specific* thing – like breathing, playing tennis, or writing a legal brief. Rather, it refers to a unified collection of innumerable specific abilities, collected under one all-encompassing, unitary "ability." In order to refer to this single, integrated "ability" that includes all specific abilities, it was entirely natural for the Legislature to have adopted the plain language convention of referring to a person's "*general* ability" to live his normal life. In this way, "general ability" really does mean simply "ability" – it makes clear that the statute is referring to one unitary "ability" that includes all specific abilities.

The word "general" therefore operates simply to make clear that the word "ability" is used in its maximum, unrestricted sense. This interpretation of the word "general" when paired with the word "ability" is entirely in keeping with the dictionary definition of the word "general" in isolation:

> **general** *adj.***1.** Concerned with, applicable to, or affecting the whole or every member of a class or category. **2.** Affecting or characteristic of the majority of those involved; prevalent. **3.** Being usually the case; true or applicable in most instances. **4.a.** *Not limited in scope, area or application.* **b.** Not limited to or dealing with one class of things; diversified. **5.** Involving only the main features rather than precise details.

Def Br at 28 (quoting the *American Heritage College Dictionary* 566 (3d ed 1997)) (emphasis added). Defendant seizes on the first definition of the term "general" to support his argument that the Legislature intended to restrict tort remedies to impairments that affect *all* of the particular abilities that comprise the "general ability to lead [one's] normal life." But it is obvious that the Legislature used the term to mean "[n]ot limited in scope, area or application."[10]

Indeed, that is precisely how "general" operates in conjunction with a host of nouns akin to "ability." For example, Webster's Third defines the term "general agent" as "one employed to transact generally all legal business of his principal entrusted to him or to do all acts connected with a particular trade, business, or employment . . . ." *Webster's Third New International Dictionary* 944 (1964, 1967). Likewise, a "general appearance" is one "made in general terms giving a court full and absolute jurisdiction in the matter in issue." *Id.* A "general court martial" is "a court martial having the authority to try any offense against military law and to impose a sentence of dishonorable discharge or of death when provided by law." *Random House Dictionary of the English Language* (unabridged 2d ed 1987). A "general deputy" is "a deputy authorized to exercise the whole of the powers of another official." *Webster's Third New International Dictionary* 945 (1993) A "general hospital" is one "which does not confine itself

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[10] See also *Webster's Third New International Dictionary* 944 (1964) (defining "general" as "5 : not confined by specialization or careful limitation : not limited to a particular class, type, or field : inclusive and manifesting or characterized by scope, diversity, or variety"); *Webster's College Dictionary* 555 (1991) ("3. not limited to one class, field, product, service, etc."); *Webster's II New College Dictionary* 465 (2001) ("4. a. Not limited in scope, area, or application").

to patients suffering from one particular class of disease or to those of a particular sex or age-group." *Oxford English Dictionary* 432 (2d ed 1989). A "general law" is "a law unrestricted as to time and applicable throughout the entire territory subject to the power of the legislature that enacted it and applying to all persons in the same class in the same situation." *Webster's Third New International Dictionary* 945 (1993). A "general lien" is "a lien for the satisfaction of a balance due from an owner of personal property not confined to the amount due in respect of the property itself." *Id.* A "general partner" is "a partner whose liability for partnership debts and obligations is unlimited." *Id.* A "general power of appointment" is "a power to appoint property that can be exercised entirely in favor of the donee, his nominee, or his estate." *Id.* A "general practitioner" is one "whose practice is not limited to any specific branch of medicine or class of diseases." *Webster's College Dictionary* 555 (1991). "[G]eneral property" refers to "the absolute ownership usu. of property with the right of complete dominion over it including the incidental rights of possession, of use and enjoyment, and of disposition or alienation." *Webster's Third New International Dictionary* 945 (1993). A "general tail" is "a fee-tail estate not restricted to particular descendants of the first owner thereof but designed to pass to all of said owner's descendants so long as such issue is alove." *Id.*

Thus, in innumerable instances akin to the phrase "general ability," the word "general" signifies the *unlimited* or *unqualified* nature of the noun in question, such that any limitation or qualification must necessarily affect the "general" quality of that noun. Indeed, this is precisely the definition that the term "general" has been accorded when interpreted by this Court in contexts closely analogous to this case. For example, in *Cox v Board of Hospital Managers for the City of Flint*, 467 Mich 1, 18, 651 NW2d 356 (2002), this Court was called upon to determine

the applicable standard of care in reference to the statutory terms "general practitioner" and "specialist." Its reasoning is instructive here:

> The statute does not define "general practitioner" or "specialist." When faced with questions of statutory interpretation, our obligation is to discern and give effect to the Legislature's intent as expressed in statutory language. Undefined statutory terms must be given their plain and ordinary meanings. When confronted with undefined terms, it is proper to consult dictionary definitions.
>
> *Random House Webster's College Dictionary* (1997) defines "*general* practitioner" as "a medical practitioner whose practice *is not limited* to any special branch of medicine." "Specialist" is defined as "a medical practitioner who deals only with a particular class of diseases, conditions, patients, etc."

Id. at 18-19 (internal citations omitted) (emphases added). The *Cox* case follows the approach taken by the Court more than a century ago, in *Kendell v Bishop*, 76 Mich 634, 43 NW 645 (1889), in determining whether a particular instrument effected a "general assignment" such that it was void. There, the Court held:

> The direct effect of this instrument . . . is to put the entire assets, legal and equitable, into the hands of a trustee for sale and distribution. This is precisely what is done by any *general* assignment; and, if there is any distinction between this and other common-law assignments, it is that *this trustee is given powers which would be unlawful as against creditors by the common law.* An assignment of all one's assets to an assignee for the benefit of creditors is within all the definitions of a general assignment. *It is the completeness of the transfer* that gives it character.

Id. at 640 (internal citations omitted) (emphases added). Thus, the essence of a *general* "ability" is simply that it is plenary, complete, and operates without limitation. And a general "ability" necessarily includes all, and every, particular "ability" within its scope.[11]

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[11] Decisions of the United States Supreme Court are to the same effect. See *Concerned Citizens of Southern Ohio, Inc v Pine Creek Conservancy Dist*, 429 US 651, 659, 97 S Ct 828, 51 L Ed 2d 116 (1977) (emphases added) ("the scope of powers granted to a conservancy district itself are *so narrowly confined* as not to call into play the strict application of one-man, one-vote doctrines. Conservancy districts, established solely for flood prevention and control, do not exercise '*general* governmental powers,' as that phrase was defined in *Avery v Midland County*, 390 US 474 (1968). Rather, flood control is a 'special limited purpose. . . .' "); *Salyer Land Co v Tulare*

It follows from these precedents that if the plaintiff's "general ability" is compromised in any of its particulars by virtue of an impairment, then it is no longer the same "plenary," "complete," or "unqualified" ability that it was before the injury. A plaintiff who demonstrates an objectively manifested impairment to an important body function is entitled to pursue his tort remedies if his "unlimited" or "unrestricted" ability to lead his normal life has been adversely affected by that impairment. This is the standard that flows from the plain meaning of the phrase "general ability" as used here.

B. Defendant's And ACIA's Interpretation Of The Word "General" Would Produce Nonsensical Results

Defendant follows his citation of the dictionary definition of the isolated term "general" with the following assertion, which lies at the heart of his appeal:

> The plain and ordinary meaning of the term "general," in the context of examining what type of ability [that] is affected by an impairment, thus does not allow for reliance on *particular* inabilities or difficulties in a person's life; yet it is clear that the Court of Appeals relied on such inabilities or difficulties.

Def Br at 28.

This is pure nonsense. Whatever else the word "general" may mean, it cannot possibly mean that "reliance on *particular* inabilities or difficulties in a person's life" is not allowed. Indeed, as previously demonstrated, the term "general ability" necessarily includes within its

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Lake Basin Water Storage Dist, 410 US 719, 727-28, 93 S Ct 1224, 95 L Ed 2d 659 (1973) (emphases added) ("The appellee district in this case, although vested with some typical governmental powers, has *relatively limited* authority," such that it does not "exercis[e] *general* governmental power."); *Moran v Commissioner of Internal Revenue*, 309 US 78, 81, 60 S Ct 424, 84 L Ed 585 (1940) (emphases added) ("None of the revenue acts has defined the phrase '*general* power of appointment.' The distinction usually made between a general and a special power lies in the circumstance that, under the former, the donee *may appoint to anyone*, including his own estate or his creditors, thus *having as full dominion over the property as if he owned it*; whereas, under the latter, the donee may appoint only amongst a restricted or designated class of persons other than himself. *We should expect, therefore, that Congress had this distinction in mind when it used the adjective 'general.'* ").

scope each particular ability. If Defendant's interpretation were correct, then even a person who suffers the "particular inabilities" of being unable to walk, talk, see, or hear, would nonetheless not succeed in demonstrating an affect on his "general ability" to lead his normal life, because to do so he would have to point to each of those four "particular inabilities." Thus, while it is true that the *word* "general" means both "involving only the main features rather than precise details," and "affecting the whole or every member," those definitions are obviously inapt here, and actually lend further support to Plaintiff's understanding of the *phrase* "general ability" as meaning "single, unified, and unqualified ability." In any event, the Legislature obviously did not intend to preclude courts from looking at the effect of an impairment on *particular* abilities. That would be absurd, and would create a standard that precious few plaintiffs – those who are entirely incapacitated by the impairment – could satisfy.

Similarly, the ACIA argues that "in light of the dictionary definition of 'general,' " a court is required to examine "all aspects of the person's life." ACIA Br at 33-34. ACIA goes on to explain:

> In addition to the "activities" listed by the Court of Appeals, there are myriad other aspects of living. Most significantly, there are basic human functions such as thinking, seeing, talking, eating, walking, sitting, standing, lifting, sleeping, personal hygiene, dressing, etc.
>
> Identifying which (if any) of the basic human functions has been affected (and by how much and for how long) should be the starting point in analyzing whether the injury affected the person's 'general' (i.e., overall) ability to live his or her normal life.

ACIA Br at 34.

This is, with respect, preposterous. It is inconceivable that the Legislature intended courts to march through an infinite list of *each and every aspect* of living life before reaching a conclusion as to whether a plaintiff's normal life has been affected by the impairment at issue. The statute does not call for an inquiry, as ACIA claims, into all of the numerous and sundry

abilities involved in living a normal life. See ACIA Br 33-34. Indeed, under ACIA's view, there is no apparent limit to the number of various "abilities" that must be examined, nor is there any apparent acknowledgement that the standard may be satisfied if only *some* discreet abilities are affected, while many others are unaffected.

This notion that one's "general ability to lead his normal life" cannot be affected unless all aspects, or perhaps some critical mass of aspects, of living are affected, is akin to saying that a court's "general jurisdiction" over civil cases would be unaffected by a statute forbidding it from hearing tort cases, unless that court is forbidden from hearing all other civil cases as well. Yet it surely could not be clearer that a court's "general jurisdiction" would be "affected" by elimination of its authority to hear tort cases, even if the rest of its jurisdiction remained unchanged. Likewise, under Defendant's interpretation, a victim of an automobile accident who is left in a comatose state may remain able in some sense to sleep, breathe, dream, drink, and eat (albeit intravenously), and therefore the plaintiff's *whole* ability to lead a normal life nonetheless remains unaffected because *some parts* of that normal life remain intact. That, of course, is not what the Legislature intended in Section 3135.

We are obviously taking ACIA's and Defendant's argument to its extremes, but these extremes flow directly from the argument advanced in their briefs. Emphasizing that "general" is defined as "affecting the whole or every member of a class or category," Defendant argues that the Court of Appeals erred in considering only a number of "particular" abilities, instead of examining *all* of Plaintiff's abilities. See Def Br at 28-30; ACIA Br at 33-34. The most reasonable reading of this argument is that the court ought at least to determine that some "critical mass" of abilities have been affected before it can complete its analysis. But even that suggestion is implausible: a court cannot determine that it has examined a "critical mass" of

"affected abilities" when the total set of abilities is literally unlimited. Defendant and ACIA give no indication at all as to whether there are any abilities that need not be considered, even insisting that "personal hygiene" and "dressing" must be included. Moreover, the whole concept of having to "check the box" on an unending number of specific abilities contradicts the statutory language: again, the phrase "general ability" refers to a unified whole – one *single* ability composed of countless specific abilities – and an impairment that affects any of the plaintiff's specific abilities necessarily affects the plaintiff's general ability.

Aside from their obviously untenable assertion that "*all* aspects of a person's life must be examined," ACIA Br at 34, Defendant and ACIA also criticize the Court of Appeals for placing excessive reliance upon the impairment's effect on Plaintiff's "ability to work as a carpenter." *Id.* While conceding that it is "obvious" that "a person's job virtually *always* plays a significant role in his or her life," Def Br at 30, Defendant and ACIA argue that an impairment's impact on work ought not to be a factor in applying the "general ability" test because "an injured person can recover up to three years of no-fault benefits for work," and "[i]f the person's work loss exceeds" the no-fault caps, "those excess economic losses can be recovered in a third-party lawsuit." ACIA Br at 34-35; see also Def Br at 30-31. But the fact that economic losses can be recovered in no way diminishes the fact that when a plaintiff cannot perform his job after an accident at the same level that he did prior to the accident, his "general ability to lead his normal life" has been impacted. For instance, if an injury completely precluded a plaintiff from performing the job he had prior to the accident, thereby requiring him to get a new job, but left intact his ability to engage in all of the other activities he engaged in prior to the accident, it surely cannot be doubted that his "general ability to live his normal life" has been impacted. That he could recover economic damages for any loss in earnings resulting from his change in

job in no way undermines the reality that his normal life has been dramatically affected: indeed, even if he can make *more* money in his fall-back job – say, because his career as a musician has been destroyed and he must return to the profession of accounting – it is nonetheless the case that a plaintiff whose *chosen vocation* has been terminated as a result of an accident has suffered an "affect on his general ability to lead his normal life."

And as the Court of Appeals said, at least "where the job plays a significant role in that individual's normal life," the plaintiff's general ability to lead that normal life will be affected by an impairment that demonstrably diminishes his ability to perform that job. 256 Mich App at 688. To be sure, if the impairment's effect on work is *de minimis*, this will not be the case. But where the impairment's effect on work is demonstrable and more than *de minimis*, then it will likely necessarily adversely affect that person's normal life, since "[e]mployment or one's livelihood, for a vast majority of people, constitutes an extremely important and major part of a person's life." Indeed, given that "our worth in society is often measured by our employment," if the Legislature had intended to exclude or in any way diminish the consideration to be given under Section 3135(7) to the work-impact of an impairment, it would surely have said so quite clearly.

ACIA itself provides a telling illustration of the extreme results to which its analysis purposefully leads. It argues that a concert violinist whose career is ended by an injury to his hand should be held not to have an impairment that "affects the general ability of [that person] to live his normal life." This cannot be what the Legislature intended. The whole point of a subjective "normal life" test is to ensure that the personal story of each plaintiff is determinative, for better or for worse. It is irrelevant to a plaintiff whose normal life is profoundly affected by an injury that the same injury would not have affected the normal lives of the next thousand

people. And a person whose chosen professional life is ended has surely suffered an "affect on his normal life." Can it really be doubted that a concert violinist is entitled to seek noneconomic damages for a career-ending injury, notwithstanding the fact that he can still teach others to play the instrument? We hasten to emphasize that an impairment need not be career-ending to qualify under Section 3135(7). So long as the effect of the impairment on the plaintiff's normal life is not *de minimis*, it satisfies both the plain language and legislative purpose of the statute.

Defendant and the ACIA complain that the Court of Appeals erred in engaging in an "altered lifestyle" analysis – i.e., in comparing, as a general matter, how the particular plaintiff's normal life was altered by the accident. ACIA calls this a "bare" altered lifestyle analysis, ACIA Br at 35-36, yet it is hard to imagine a better way of capturing the inquiry into whether there has been an affect on a plaintiff's "general ability to lead his normal life." To undertake this inquiry, a court must consider the normal life Plaintiff led before suffering the injury in question, and ask whether Plaintiff's singular, unitary ability to lead that normal life has been impaired by the intervening injury. The ultimate question is whether that ability, as a whole, has been adversely affected by the impairment caused by the injury. Answering this question necessarily entails an analysis of both qualitative factors (i.e., what activities are affected and whether they matter to the plaintiff's normal life), and quantitative ones (i.e., to what extent have the activities been impacted and how large a portion of plaintiff's life do they occupy). As explained below, that is precisely the analysis the Court of Appeals engaged in its opinion on remand in this case.[12]

In short, Defendant and ACIA seek to reinstate the *Cassidy* era objective "normal life" standard, which essentially restricted recovery of noneconomic damages to plaintiffs who were "bedridden, cannot care for themselves, or are unable to perform any type of work." *DiFranco*,

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[12] See *Kreiner v Fischer (On Remand)*, 256 Mich App 680, 687-90 & n 6, 671 NW2d 95 (2003).

427 Mich at 66. The Legislature plainly rejected that standard, adopting instead the subjective normal life standard. *Id.*

C. This Court Has Already Recognized The Difference Between A "Serious Impairment," Which The Legislature Has Required, And A "Serious Effect," Which It Has Not

Defendant's brief, from beginning to end, is devoted to the singular purpose of persuading this Court to judicially engraft a "seriousness" component onto the "general ability" prong of the statutory threshold. In his Introduction, Defendant asks this Court to conclude that the "alleged effect [of Plaintiff's impairment] on his general ability to lead his normal life is not sufficiently 'serious' to meet the no-fault tort threshold." Def Br at 15. The brief concludes by urging that the circuit court "was correct in its analysis" that " 'Plaintiff is hard-pressed to show how the alleged impairment is *serious enough* to affect his normal life.' " Def Br at 36 (quoting 66a - Tr 1/24/00, p 10).

The problem with Defendant's attempt to import a "seriousness" requirement into the "general ability" inquiry is simply that, unlike the statute interpreted in *Cassidy*, Section 3135 now has an explicit statutory definition of the phrase "serious impairment of body function." That definition, as noted earlier, contains three separate prongs: the impairment must be "objectively manifested," must be to "an important body function," and must be one that "affects the person's general ability to lead his or her normal life." MCL 500.3135(7). In short, the Legislature has itself explicitly defined what "serious" means in the phrase "serious impairment of body function" as set forth in Section 3135(1), and that is the end of the matter. It would be entirely inappropriate for the Court to import into any one of the three prongs of that definition an additional, extra-statutory "seriousness" requirement. Rather, this Court's "foremost" role, as it has often emphasized, is "to discern and give effect to the intent of the Legislature," and to

"examin[e] the language of the statute itself" as the " 'most reliable evidence of [that] intent.' " *Sun Valley Foods Co v Ward*, 460 Mich 230, 236, 596 NW2d 119 (1999) (citing cases).

Indeed, this Court has already, in its order remanding this case last year, effectively recognized the definitional relationship between the "serious impairment" requirement imposed by Section 3135(1) and the "affect on a person's general ability to lead his or her normal life" required by Section 3135(7), which does not have its own seriousness requirement. The Court noted as follows:

> In our judgment, both the circuit court and the Court of Appeals erred. Although a *serious* effect is not required, *any* effect does not suffice either. Instead, the effect must be on one's *general* ability to lead his normal life.

468 Mich 884.

Defendant is wrong when he states that "Plaintiff's position in this litigation has been that the adjective 'serious,' as used in the statutory phrase 'serious impairment of body function,' is essentially immaterial." Def Br at 15. We do not contend that the adjective "serious" is at all immaterial. We contend, rather, that the meaning of the statutory phrase "serious impairment of body function" has been carefully considered and specifically defined by the Legislature itself. And the Legislature has determined that if an injury is objectively manifested, if it impairs an important body function, and if it affects the victim's normal life, then the impairment is necessarily serious – nothing more is required, or permitted. To be sure, each of the three prongs to the statutory definition helps ensure that only serious impairments will satisfy the threshold – (a) the "objective manifestation" test ensures that a medically unidentifiable impairment will not qualify; (b) the "important body function" test ensures that impairments to incidental or unimportant body functions will not qualify; and (c) the "normal life" test ensures that the impairment demonstrably adversely affects the unique, *particular* life of the *particular* plaintiff

at issue. If that plaintiff's "normal life" is unaffected, then he cannot bring suit, despite the fact that the injury may have had an effect on some peripheral aspect of plaintiff's life and despite the fact that another plaintiff, suffering an identical injury, is allowed to sue because *his* "normal life" is demonstrably adversely affected by the impairment. Nor does an impairment that causes only a *de minimis* effect on the plaintiff's normal life satisfy the three-part, statutory definition of "serious impairment" enacted by the Legislature. It is the subjective "normal life" part of the third prong that performs the heavy work of ensuring that only impairments that alter the plaintiff's "normal life" satisfy the threshold while *de minimis* impairments do not. Thus, the court's assessment of the "normal life" of each particular plaintiff will ensure that only injuries that are serious – in the sense of causing a life-altering impairment with respect to the particular plaintiff – will satisfy the threshold.

Finally, both Defendant and the ACIA argue that the issue presented in this case should be resolved by interpreting the "serious impairment" threshold on a par with the other two threshold standards set forth in the no-fault act – death and serious, permanent disfigurement. Def Br at 24-25. In doing so, they cite to legislative history stating that "[t]he expression 'serious impairment of body function' must be understood in connection with the other tort thresholds, death and permanent serious disfigurement. These are high standards." Def Br at 27 (quoting 55a - House Legislative Analysis Section, HB 4341, 1995 PA 222 (12/18/95), p 3). This line of reasoning is easily overstated. Of course, the three thresholds are all "high" in that they require either death or a "serious" disfigurement or impairment. But that certainly does not mean that the three different thresholds set forth in MCL 500.3135(1) are somehow intended to represent "coequal" standards that must be commensurate with one another. That obviously

cannot be the case: the first threshold is *death*, and, needless to say, there are ***no*** "disfigurements" or "impairments" that rise to that ultimate level.

Moreover, it is clear that the "serious, permanent disfigurement" threshold and the "serious impairment" threshold are not dissimilar. In 1995, the Legislature made clear that it intended the "serious impairment" threshold to "weed out" only what it called "*undeserving* and *frivolous* cases." 54a - House Legislative Analysis Section, HB 4341 as enrolled, 1995 PA 222 (12/18/95), p 2 (emphases added). The case law that has applied the "serious disfigurement" threshold is consistent with this. See, e.g., *Sanders v Cantin*, No 240065, 2003 Mich App LEXIS 2294 (Sept 16, 2003) (permanent six-inch stomach scar is serious permanent disfigurement although not a serious impairment). To be sure, the "disfigurement" and the "impairment" prongs are not symmetrical; they require different things in an effort to "weed out" the "frivolous" and "undeserving" claims: the "serious disfigurement" prong does *not* require a showing that the disfigurement has had an "affect on the plaintiff's ability to live a normal life"; and the "serious impairment" prong does not require that the impairment be "permanent." But both thresholds operate in a parallel fashion to exclude undeserving claims.

D. This Court Should Reject Defendant's Suggestion To Add Additional Prongs To The Statutory Definition Of "Serious Impairment Of A Body Function"

Defendant argues that "[a] decisional framework, such as the one propounded by the Court in *Kern*, [*v Blethen-Coluni*, 240 Mich App 333 (2000)], is necessary as a basis for the trial courts, and the Courts of Appeal, to build a body of precedent that will foster consistent and predictable results in claims of serious impairment of body function." Def. Br. at 32. Thus, Defendant offers "three related criteria to be considered for determining whether a claimed impairment of a body function is one that should be deemed to 'affect[ ] the person's *general ability* to lead his or her normal life." *Id.* (alteration in original). Those three criteria are

"gravity of the impairment, duration of the impairment, and pervasiveness of the impairment." *Id.* Likewise, ACIA submits six "proposed rules of law" that it believes will aid the Court in resolving the correct meaning of the "general ability" standard.

As an initial matter, Defendant's reliance upon *Kern* as a template for how this case should be decided is entirely misplaced. Although Defendant accuses the Court of Appeals of having "to run and hide" from *Kern*, that case said nothing at all about the proper interpretation of the phrase "general ability live his or her normal live." Its only reference to certain "nonexhaustive factors" to be considered in determining the seriousness of the impairment came in conjunction with its citation to decisions of this Court that were issued *prior* to the enactment of the 1995 amendments specifically defining the phrase "serious impairment." Moreover, *Kern* held that the plaintiff there satisfied the "serious impairment" threshold because his broken leg caused him to miss three weeks of school and to be unable to walk normally for a total of eleven weeks, even though he subsequently "returned to walking and other normal activities." *Kern v Blethen-Coluni*, 240 Mich App 333, 335, 612 NW2d 838 (2000). It therefore only confirms that a temporary disruption of normal life activities can satisfy the "general ability" test.

More fundamentally, the proposed "decisional framework" advanced by Defendant and ACIA should be rejected as a naked invitation for this Court to engage in judicial redrafting of the no-fault statute's definition of "serious impairment of body function." The Legislature specified its own three-prong test for determining whether the impairment threshold within the no-fault scheme has been satisfied. Now, Defendant and his amici seek to create yet another "non-exhaustive" list of "factors," each one of which must be satisfied in order to satisfy just one of the prongs in the three-pronged test enacted by the Legislature. There is no basis for judicially engrafting these kinds of add-on requirements onto the plain language of the statute.

In any event, identifying additional prongs in the analysis, which were not selected by the Legislature, will only lead to greater, not less, confusion. After all, the more prongs or "factors" there are in the test, the more uncertainty there is in any given situation. These open-ended – and nonexhaustive – factors are not intended by defendant and its amici to clarify the analysis. Rather, they are intended only to provide greater opportunity for argumentation by lawyers.

Both this Court and the United States Supreme Court have frequently recognized that legal problems that involve " 'questions of degree' " normally " 'cannot be disposed of by general propositions,' " such that it would be a mistake for a court to attempt to invent any "set formula" in an effort to provide guidance for all future cases. *Blue Cross & Blue Shield v Milliken*, 422 Mich 1, 109, 367 NW2d 1 (1985) (quoting *Pennsylvania Coal Co v Mahon*, 260 US 393, 416, 43 S Ct 158, 67 L Ed 322 (1922)). These kinds of problems arise in areas as diverse as whether a taking of property has occurred within the meaning of the Fifth Amendment, see *id.*; whether particular activity is a "trade or business" under the Tax Code, *Commissioner of Internal Revenue v Groetzinger*, 480 US 23, 36, 107 S Ct 980, 94 L Ed 2d 25 (1987) (Court expressed "concern that an attempt judicially to formulate and impose a test for all situations would be counterproductive, unhelpful, and even somewhat precarious for the overall integrity of the [Tax] Code"); whether a defendant's confessions should be admissible, *Michigan v Jackson*, 475 US 625, 636-37, 106 S Ct 1404, 89 L Ed 2d 631 (1986) (Burger, CJ, concurring) (warning against "an absolutist, mechanical treatment of the subject," and in favor of "sound, common-sense boundaries"); or whether "probable cause" exists for a search and seizure, *Illinois v Gates*, 462 US 213, 230-41, 103 S Ct 2317, 76 L Ed 527 (1983) (rejecting use of specific, judicially-created "tests," in lieu of consideration of "totality-of-the circumstances," since "probable cause is a fluid concept – turning on the assessment of probabilities in particular

factual contexts – not readily, or even usefully, reduced to a neat set of legal rules"). These cases all favor a common sense approach to solving legal problems that, like the question whether an impairment has had an effect on a plaintiff's "general ability to lead his normal life," are often simply not susceptible to certain resolution through abstract legal formulas. See also *Daley v LaCroix*, 384 Mich 4, 11 n 7, 179 NW2d 390 (1970) ("magic words and incantations are as fatal to our science as they are to any other") (quoting Selected Writings of Benjamin Cardozo, The Growth of the Law, at 215).

Thus, this Court should resist the invitations from Defendant and ACIA to engraft new tests on top of the three specific requirements set forth by the Legislature in its specific definition of "serious impairment of body function." Those requirements, if left unadorned with further sub-tests and sub-prongs, will yield guidance as more and more cases are resolved. And while very difficult cases will surely arise in the future, where the impairment's claimed effect on the plaintiff's life seems to fall right on the margin between that which clearly does have a "life-altering" impact on his *normal* life, and that which impacts his life in a frivolous, *de minimis* fashion, this is not such a case. Here, Plaintiff's injury has caused a 25% reduction in his ability to work at his job on a daily basis, and he has suffered that reduction – and the chronic pain that is its root cause – for the past six years. His injury is "objectively manifested" through x-rays and MRIs, and the ability to use the lower back is undoubtedly an important body function. Thus, this is not a "hard case," and the Court should not strain here to articulate extra-statutory tests that will do little to help resolve the hard cases that may arise in the future. See generally *Michigan v Jackson*, 475 US at 636-37 (Burger, CJ, concurring) (recognizing "the ancient axiom that hard cases make bad law").

Finally, even if this Court did accept the extra-statutory tests identified by Defendant and ACIA, Plaintiff would plainly satisfy them. His impairment is of sufficient "gravity," since it has directly caused sharp limitations on his ability to perform his professional work and to engage in his favorite pastime. Its "duration," as noted above, is in part permanent and in part indefinite. Likewise, the "pervasiveness" of the impairment's effect on Plaintiff's normal life also cannot be doubted: by substantially disrupting both his work life and his personal life for more than six years now, it necessarily has "pervaded" all aspects of his normal life that require a pain-free back, hip, and leg, which necessarily includes walking, running, lifting, climbing, and performing rigorous manual labor – in short, the activities that are essential to the normal life of a carpenter and a hunter. Thus, just as this is not a "hard case" under the statutes enacted by the Legislature, it is also not one that has any difficulty satisfying the extra-statutory tests suggested by Defendant.

III. THE COURT OF APPEALS DECISION ON REMAND ILLUSTRATES THE PROPER APPLICATION OF THE "GENERAL ABILITY" PRONG

In response to this Court's remand, the Court of Appeals reexamined its earlier analysis, and explicitly clarified that it was not holding that "*any* effect will suffice, but rather that 'the third prong of the statutory definition explicitly requires only that the impairment affect[] the person's general ability to lead his or her normal life.' " 256 Mich App at 686 (internal quotation marks and citations omitted). The Court then emphasized:

> To the extent that our earlier opinion can be read to implicitly suggest that *any* effect will suffice, and consistent with the Supreme Court's remand order, we now make clear that *any* effect does not suffice to establish a serious impairment of body function under MCL 500.3135, rather the effect must relate to a person's general ability to lead his or her normal life. This leads to the issue regarding the meaning of the phrase "affects the person's general ability to lead his or her normal life." MCL 500.3135(7).

256 Mich App 686-87.

Because of this Court's emphasis on the word "general" in its remand order, the Court of Appeals expanded upon its prior opinion in an effort to define the "general ability" standard in reference to both qualitative and quantitative factors that bear upon the effect an impairment has on a particular plaintiff's normal life. First, it analyzed the qualitative import of Plaintiff's work to the rest of his normal life. While Defendant concedes that it is "obvious" that "a person's job virtually always plays a significant role in his or her life," Def Br at 30, it does so in an effort to mischaracterize the standard applied by the Court of Appeals as one under which "*any* injury otherwise satisfying the elements of the tort threshold . . . that *in any way* affects or 'impacts' the person's ability to work would test positive." Def Br at 30-31 (emphases added). That caricature of the Court of Appeals' decision is simply false: the Court did not hold that "any" impact on the plaintiff's employment would satisfy Section 3135(7). To the contrary, it articulated its core holding as follows: "An injury affecting one's employment and ability to work, *under the right factual circumstances*, can be equated to affecting the person's *general* ability to lead his or her normal life." 256 Mich App at 688 (first emphasis added). Likewise, it was careful to explain that "one's general ability to lead his or her normal life *can* be affected by an injury that impacts the person's ability to work at a job, *where the job plays a significant role in that individual's normal life*." *Id.* (emphasis added). These are not categorical statements. Rather, they are the statements of a common-law court attempting to provide a limited holding as to why the particular plaintiff before it should prevail: in this case, Plaintiff is a carpenter, and the Court emphasized the existence of "documentary evidence . . . indicating that plaintiff's ability to work a full eight-hour day was reduced by twenty-five percent, that he could no longer do roofing jobs, that ladder work was limited, and that there were weight and movement

restrictions." *Id.* at 690. It thereby quantified the impact that Plaintiff's injuries have had on the work that is central to his normal life.

Second, the Court also identified ways in which the demonstrated impact on Plaintiff's employment would also qualitatively impact other aspects of his particular normal life. It explained that, for people in Plaintiff's circumstances, who typically work 40 hours or more each week, employment "constitutes an extremely important and major part" of their lives, which often determines their "worth as individuals in society." *Id.* at 688. While those statements may be true of many people in society, the Court was careful to focus its analysis on the particular "normal life" of this particular Plaintiff, emphasizing in particular the "documentary evidence presented by plaintiff that his ability to walk, undertake certain physical movements, and engage in recreational hunting was limited by the injury." *Id.* at 689.

Third, the Court of Appeals rebutted Defendant's argument that, as a quantitative matter, a 25% reduction in Plaintiff's ability to work was not a "sufficiently serious" effect on his normal life to satisfy the threshold set forth in Section 3135. See 256 Mich App at 688-90. After explaining that this Court had already made clear that there is no "serious effect" requirement, the Court of Appeals nonetheless held that even if there were such a requirement, Plaintiff would clearly satisfy it, since a 25% reduction in work capability and the diminishment of a variety of other abilities must necessarily be "significant enough" even to clear Defendant's extra-statutory threshold.

In sum, the Court of Appeals held that Mr. Kreiner's "normal life" was undeniably affected by his injury. Whether the identical injury would constitute a "serious impairment" to the normal life of any other Plaintiff was beside the point and was, accordingly, not addressed. Thus, the Court of Appeals' remand decision illustrates that whether a particular injury affects a

plaintiff's "normal life" has everything to do with the circumstances that define that particular plaintiff's "normal life" and their interplay with the injury in question, and very little to do with how the word "general" is defined. For as shown above, the phrase "general ability" simply means "ability" in the broadest, most expansive sense possible – consistent with the use of the word "general" in a host of other contexts, it signifies plaintiff's singular, unitary, unlimited and unqualified ability to live his normal life. A limitation or qualification on that ability, therefore, must satisfy the threshold.

CONCLUSION

For the forgoing reasons, the decision of the Court of Appeals should be affirmed.

Respectfully submitted,

George T. Sinas /by VJC

GEORGE T. SINAS (P25643)
SINAS, DRAMIS, BRAKE,
BOUGHTON & McINTYRE P.C.
3380 Pine Tree Road
Lansing, Michigan 48911
(517) 394-7500

Terry L. Cochran /by VJC

TERRY L. COCHRAN (P35890)
COCHRAN, FOLEY
& ASSOCIATES, P.C.
15510 Farmington Road
Livonia, Michigan 48154
(734) 425-2400

Charles J. Cooper /by VJC

CHARLES J. COOPER (*pro hac vice*)
HAMISH P.M. HUME
DEREK L. SHAFFER
COOPER & KIRK, PLLC
1500 K Street, N.W.
Suite 200
Washington, D.C. 20005
(202) 220-9600

March 8, 2004

Attorneys for RICHARD ADAM KREINER

ADDENDUM 1

3 of 3 DOCUMENTS

*** THIS DOCUMENT IS CURRENT THROUGH P.A. 322, 1/9/04 ***
*** WITH THE EXCEPTION OF P.A. 299 THROUGH 306 ***

CHAPTER 500 INSURANCE CODE OF 1956
THE INSURANCE CODE OF 1956
CHAPTER 31. "NO-FAULT" AUTOMOBILE PROVISIONS

GO TO CODE ARCHIVE DIRECTORY FOR THIS JURISDICTION

MCLS § 500.3135 (2003)

MCL § 500.3135

§ 500.3135. Tort liability for noneconomic loss; action for damages pursuant to subsection (1); abolition of tort liability; exceptions; action for damages pursuant to subsection (3)(d); commencement of action; removal; costs; decision as res judicata; "serious impairment of body function" defined.

Sec. 3135. (1) A person remains subject to tort liability for noneconomic loss caused by his or her ownership, maintenance, or use of a motor vehicle only if the injured person has suffered death, serious impairment of body function, or permanent serious disfigurement.

(2) For a cause of action for damages pursuant to subsection (1) filed on or after July 26, 1996 , all of the following apply:

(a) The issues of whether an injured person has suffered serious impairment of body function or permanent serious disfigurement are questions of law for the court if the court finds either of the following:

(i) There is no factual dispute concerning the nature and extent of the person's injuries.

(ii) There is a factual dispute concerning the nature and extent of the person's injuries, but the dispute is not material to the determination as to whether the person has suffered a serious impairment of body function or permanent serious disfigurement. However, for a closed-head injury, a question of fact for the jury is created if a licensed allopathic or osteopathic physician who regularly diagnoses or treats closed-head injuries testifies under oath that there may be a serious neurological injury.

(b) Damages shall be assessed on the basis of comparative fault, except that damages shall not be assessed in favor of a party who is more than 50% at fault.

(c) Damages shall not be assessed in favor of a party who was operating his or her own vehicle at the time the injury occurred and did not have in effect for that motor vehicle the security required by section 3101 at the time the injury occurred.

(3) Notwithstanding any other provision of law, tort liability arising from the ownership, maintenance, or use within this state of a motor vehicle with respect to which the security required by section 3101 was in effect is abolished except as to:

(a) Intentionally caused harm to persons or property. Even though a person knows that harm to persons or property is substantially certain to be caused by his or her act or omission, the person does not cause or suffer that harm intentionally if he or she acts or refrains from acting for the purpose of averting injury to any person, including himself or herself, or for the purpose of averting damage to tangible property.

(b) Damages for noneconomic loss as provided and limited in subsections (1) and (2).

(c) Damages for allowable expenses, work loss, and survivor's loss as defined in sections 3107 to 3110 in excess of the daily, monthly, and 3-year limitations contained in those sections. The party liable for damages is entitled to an exemption reducing his or her liability by the amount of taxes that would have been payable on account of income the injured person would have received if he or she had not been injured.

(d) Damages for economic loss by a nonresident in excess of the personal protection insurance benefits provided under section 3163(4). Damages under this subdivision are not recoverable to the extent that benefits covering the same loss are available from other sources, regardless of the nature or number of benefit sources available and regardless of the nature or form of the benefits.

(e) Damages up to $500.00 to motor vehicles, to the extent that the damages are not covered by insurance. An action for damages pursuant to this subdivision shall be conducted in compliance with subsection (4).

(4) In an action for damages pursuant to subsection (3)(e) :

(a) Damages shall be assessed on the basis of comparative fault, except that damages shall not be assessed in favor of a party who is more than 50% at fault.

(b) Liability shall not be a component of residual liability, as prescribed in section 3131, for which maintenance of security is required by this act.

(5) Actions under subsection (3)(e) shall be commenced, whenever legally possible, in the small claims division of the district court or the municipal court. If the defendant or plaintiff removes the action to a higher court and does not prevail, the judge may assess costs.

(6) A decision of a court made pursuant to subsection (3)(e) is not res judicata in any proceeding to determine any other liability arising from the same circumstances as gave rise to the action brought pursuant to subsection (3)(e) .

(7) As used in this section, "serious impairment of body function" means an objectively manifested impairment of an important body function that affects the person's general ability to lead his or her normal life.

HISTORY: Act 218, 1956, p 477; eff January 1, 1957.

Pub Acts 1956, No. 218, § 3135, as added by Pub Acts 1972, No. 294, eff March 30, 1973; amended by Pub Acts 1979, No. 145, imd eff November 13, 1979; 1979, No. 147, imd eff November 13, 1979; 1995, No. 222, eff 91 days from end of 1995 legislative session (see Mich. Const. note below).

Amended by Pub Acts 2002, No. 697, eff March 31, 2003 (see Mich. Const. note below).

ADDENDUM 2

Proposal D

1992

INITIATION OF LEGISLATION

SECTION 202

Section 202 of Chapter 2 of the Michigan Insurance Laws is hereby amended so as to add as subsection (3) thereof the provision set forth hereafter as subsection (3).

Subsection (3) NO PERSON ACTING AS COMMISSIONER OF INSURANCE MAY SERVE AS A MEMBER OF THE GOVERNING BOARD OR AS AN OFFICER OF ANY INSURER OR OTHER ORGANIZATION SUBJECT TO THE REGULATORY AUTHORITY OF THE OFFICE OF COMMISSIONER OF INSURANCE FOR A PERIOD OF 2 YEARS AFTER LEAVING THE OFFICE OF COMMISSIONER OF INSURANCE.

SECTION 2109

Section 2109 of Chapter 21 of the Michigan Insurance Laws is hereby amended so as to add as subsection (1)(d) thereof the provision set forth hereafter as subsection (1)(d).

SUBSECTION (1)(d) IN ESTABLISHING RATES FOR ITS TERRITORIES AND CLASSIFICATIONS, AN INSURER SHALL REASONABLY ANTICIPATE THAT THE RATES WILL PRODUCE A LOSS RATIO BETWEEN INCURRED LOSSES PLUS LOSS ADJUSTMENT EXPENSES AND EARNED PREMIUMS THAT IS SUBSTANTIALLY UNIFORM AMONG ITS TERRITORIES AND CLASSIFICATIONS.

SECTION 2111

Section 2111 of Chapter 21 of the Michigan Insurance Laws is hereby amended so as to add as subsection (2)(a)(IX) thereof the provision set forth hereafter as (2)(a)(IX); revise subsection (6) thereof in the manner set forth hereafter as subsection (6); delete subsections 6(a), (b), (c), (d), and (e); delete subsections (7), (8), (9), (10), and (11); and designate subsections (12), (13), (14), and (15) as subsections (7), (8), (9), and (10).

SUBSECTION 2111 (2)(A)(1X) A LACK OF ANY CLAIMS UNDER A POLICY WITH THE SAME INSURER FOR A PERIOD OF AT LEAST FIVE (5) CONSECUTIVE YEARS, ANY REDUCTION IN RATE TO BE UNIFORMLY APPLIED TO ALL WHO ARE ELIGIBLE FOR IT.

Subsection (6) Notwithstanding other provisions of this chapter, automobile insurance risks shall be grouped by territory, and territorial base rates for coverages shall be established ~~as provided in section 2111e and as follows:~~ IN COMPLIANCE WITH SECTIONS 2109 and 2110.

~~6(a) An insurer shall not be limited as to the number of territories employed in its rating plan.~~

~~6(b) Except during the period of time from February 28, 1986 to June 30, 1991, an insurer shall not employ more than 20 different territorial base rates for an automobile insurance coverage.~~

~~6(c) A territorial base rate may be made applicable in 1 or more territories contained in the rating plan of the insurer.~~

~~6(d) Except during the period of time from February 28, 1986 to June 30, 1991, an insurer shall not employ a territorial base rate for an automobile insurance package policy that is less than 45% of the highest territorial base rate for the same policy, all other rating classifications being the same.~~

~~6(e) Except during the period of time from February 28, 1986 to June 30, 1991, an insurer shall not employ a territorial base rate in a territory for an automobile insurance package policy that is less than 80% of the territorial base rate employed in any adjacent territory for the same policy, all other rating classifications being the same.~~

~~Subsection (7) Except during the period of time from February 28, 1986 to June 30, 1991, an insurer may elect at any time to exempt itself from the requirements of subsection (6) by filing an exemption with the commissioner. An insurer electing this exemption shall initially file a rating plan in which no territorial base rate for an automobile insurance package policy is less that 45% of the highest territorial base rate for the same policy, all other rating classifications being the same. Five years from the date of the initial filing the insurer shall be prohibited from using a rating plan in which any territorial base rate for an automobile insurance package policy will be less than 67% of the highest territorial base rate for that same policy, all other rating classifications being the same. An insurer's election of an exemption under this subsection is permanent, final, and not subject to change.~~

~~Subsection (8) Except during the period of time from February 28, 1986 to June 30, 1991, if an insurer can demonstrate to the commissioner, after an opportunity for an evidentiary hearing held pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.328 of the Michigan Compiled Laws, that clear and significant financial impairment exists in the geographic territory or territories in question because of the need for an additional territorial base rate, or for a greater variance in the adjacent geographic territory differential contained in subsection (6)(c), the additional territorial base rate, a greater variance, or both, shall be permitted for use by the insurer or a licensed rating organization on behalf of that insurer, at such time as the need exists. Evidence shall not include financial impairment resulting from exemptions granted to other insurers.~~

~~Subsection (9) Except during the period of time from February 28, 1986 to June 30, 1991, if the commissioner finds, solely on the evidence presented, that a greater variance in the adjacent geographic territory differential than that authorized under subsection (6)(c) is justified, the increase in variance shall not exceed 100% of that authorized under that subsection. Except during the period of time from February 28, 1986 to June 30, 1991, if an increase in variance in the adjacent geographic territory differential greater than 100% of that authorized under subsection (6)(c) is justified, the commissioner shall require the creation of an additional territorial base rate.~~

~~Subsection (10) Except during the period of time from February 28, 1986 to June 30, 1991, an exemption granted under subsections (8) and (9) shall be applicable only to the geographic territory or territories in questions, and only to the insurer requesting the exemption.~~

~~Subsection (11) Except during the period of time from February 28, 1986 to June 30, 1991, an insurer shall not have more than 5 exemptions in force at any 1 time. For purposes of determining the number of existing exemptions, each additional territorial base rate or each increase in variance in the adjacent geographic territory differential granted, shall be considered to be a separate exemption.~~

SECTION 2111a

Section 2111a of Chapter 21 of the Michigan Insurance Laws is hereby amended so as to delete subsections (1), (2), (3), (5), and (6) therefrom; designate subsection (4) thereof as subsection (1); and add as subsections (2)(a), (2)(b) (2)(c), (3)(a), (3)(b), (3)(c), (3)(d) and (3)(e) thereof the provisions set forth hereafter as subsections (2)(a), (2)(b), (2)(c), (3)(a), (3)(b), (3)(c), (3)(d), and (3)(e).

Subsection ~~(1) Except as otherwise provided in this section, before April 1, 1986, an insurer shall not charge a territorial base rate for an automobile insurance package policy in a territory within an urban area which exceeds the territorial base rate which would have been charged by the Michigan automobile insurance placement facility in that territory using the weighted average of the base rates charged in each facility territory by the 5 largest insurer groups, determined by voluntary net direct automobile insurance car years written in the state for the calendar year ending December 31, 1984 as reported to the statistical agent, and based upon the data used by the facility to determine the facility rates which were effective January 1, 1986. However, this subsection does not require an insurer to reduce its territorial base rates within an urban area which are in effect on the effective date of this section.~~

Subsection ~~(2) On and after April 1, 1986, except as otherwise provided in subsection (3), an insurer shall not increase in any 12 month period the rates for automobile insurance package policies in territories within an urban area by an amount which is greater than 4% plus the consumer price index. The insurer may redefine rating territories for automobile insurance package policies in an urban area; however, such redefinition, at the time of the redefinition, shall not result in a weighted average rate in the urban area which is greater than the weighted average rate in the urban area without redefinition of the territories. The insurer shall not use more than 6 territories within an urban area. The sum of the percentage increases for an insurer in a 12 month period as permitted under this subsection shall be less than or equal to 4% plus the consumer price index and each percentage increase shall be computed in accordance with the following:~~

> ~~The difference between the total written premium at the proposed rates minus the total written premium at current rates, divided by total written premium at current rates, and multiplied by 100.~~

Subsection ~~(3) On or after February 1, 1988, an insurer may elect to be subject to the limitations provided in this subsection instead of the limitations provided in subsection (2). An insurer electing to be subject to this subsection shall not increase the rates for automobile insurance package policies in territories within an urban area by a percentage which is greater than the insurer's nonurban average percentage increase, which nonurban average percentage increase shall be reduced by the sum of the percentage increases made by the insurer under subsection (2) during the 12 months immediately preceding the date of the filing of the proposed increase pursuant to this subsection. The insurer may redefine rating territories for automobile insurance package policies in an urban area; however, such redefinition, at the time of the redefinition, shall not result in a weighted average rate in the urban area which is greater than the weighted average rate in the urban area without redefinition of the territories. The insurer shall not use more than 6 territories within an urban area. An insurer which elects to be subject to the limitation under this subsection shall remain subject to this subsection.~~

Subsection (4) (1) Any rate filing for automobile insurance package policies made after December 15, 1985 shall not be modified, changed, or altered for a period of 6 months after the effective date of such filing. This subsection shall not prohibit an insurer from making rate filings at any time that only provide changes to rates based upon assessments levied against insurers pursuant to section 3104 or 3330. Such rate filings shall not be considered rate filings for purposes of this subsection.

Subsection ~~(5) As used in this section:~~

~~(a) "Consumer price index" means the annual average percentage increase in the Detroit consumer price index for all items for the prior 12 month period as reported by the United States department of labor and as certified by the commissioner.~~

~~(b) "Nonurban average percentage increase" means the percentage increase of an insurer's weighted average rate outside of an urban area, if any, which is obtained by dividing the weighted average of the proposed rates of the insurer outside an urban area by the highest weighted average rate of the insurer outside an urban area on file with the commissioner during the 6 months immediately preceding the date of the filing of the proposed increase, subtracting 1 from this quotient, and multiplying the difference by 100. The weights used in obtaining the weighted averages in this subdivision shall be the written car years of the insurer in each rating territory. If a negative percentage is calculated under this subdivision, there shall be no nonurban average percentage increase under this subdivision.~~

~~(c) "Urban area" means the area within the boundaries of a city in this state which has a population of 1,000,000 or more as determined by the latest of each succeeding federal decennial census and includes any city located wholly within the boundaries of a city in this state which has a population of 1,000,000 or more as determined by the latest of each succeeding federal decennial census.~~

Subsection ~~(6) This section is repealed effective July 1, 1991.~~

Subsection 2(A) ON OR BEFORE APRIL 1, 1993 RATES CHARGED BY AN INSURER FOR AUTOMOBILE INSURANCE ARE TO BE REDUCED BY AN AVERAGE OF 20 PERCENT FROM THOSE IT HAS IN EFFECT AS OF NOVEMBER 1, 1992. THE REDUCTION IS TO BE MADE IN A MANNER THAT WILL RESULT IN ITS BEING EQUITABLY DISTRIBUTED THROUGHOUT THE RATE PLAN OF EACH INSURER, AND SHALL BE MADE UNDER AN ASSUMPTION THAT THE LIMIT FOR PERSONAL PROTECTION INSURANCE BENEFITS FOR ALL POLICYHOLDERS IS THE LIMIT PROVIDED FOR BY SECTION 3107(1)(A)(i). THE REDUCTION WILL BE DEMONSTRATED IN AN APPROPRIATE RATE FILING MADE ON OR BEFORE APRIL 1, 1993.

Subsection 2(B) INCLUDED IN THE PERCENTAGE REDUCTION PROVIDED FOR BY 2(A) SHALL BE ANY REDUCTION MADE IN THE AMOUNT AN INSURER CHARGES ITS POLICYHOLDERS FOR REIMBURSEMENT OF ITS OBLIGATIONS UNDER SECTION 3104.

Subsection 2(C) IF AN INSURER CAN DEMONSTRATE TO THE COMMISSIONER THAT THE REQUIREMENTS OF (2)(A) WILL IMPAIR OR HAS RESULTED IN AN IMPAIRMENT OF ITS ABILITY TO EARN A FAIR RATE OF RETURN ON ITS AUTOMOBILE INSURANCE BUSINESS IN MICHIGAN, IT MAY APPLY TO THE COMMISSIONER FOR RELIEF FROM THE REQUIREMENTS TO THE EXTENT NECESSARY TO AVOID THE IMPAIRMENT AND THE COMMISSIONER SHALL GRANT THE RELIEF THAT IS FOUND TO BE WARRANTED.

Subsection 3(A) AS OF AUGUST 15, 1996, AND BY THAT DATE EACH YEAR THEREAFTER, AN INSURER IS REQUIRED TO MAKE THE CALCULATION DESCRIBED IN (B) OF THIS SUBSECTION SO AS TO DETERMINE IF IT IS TO PROVIDE A REFUND OF PREMIUM TO ITS THEN CURRENT POLICYHOLDERS IN THE MANNER PROVIDED FOR IN (C) OF THIS SUBSECTION.

Subsection 3(B) AN INSURER'S TOTAL AMOUNT OF ACCIDENT YEAR ULTIMATE INCURRED LOSSES AND LOSS ADJUSTMENT EXPENSES, NET OF THOSE LOSSES REIMBURSABLE TO IT UNDER SECTION 3104 OF CHAPTER 31, PLUS ITS TOTAL EXPENSES OTHER THAN LOSS ADJUSTMENT EXPENSES, SHALL BE SUBTRACTED FROM ITS TOTAL EARNED PREMIUMS EXCLUDING ANY AMOUNTS RECEIVED FROM POLICYHOLDERS FOR ASSESSMENTS OR CHARGES IMPOSED UNDER SECTIONS 3104 OF CHAPTER 31 AND 3330 OF CHAPTER 33, ALL SUCH AMOUNTS TO BE CALCULATED BY REFERENCE TO A THREE YEAR PERIOD OF TIME ENDING MARCH 31 OF THE CALCULATION YEAR AND EVALUATING THOSE AMOUNTS AS OF JUNE 30 OF THAT YEAR.

Subsection 3(C) IF THE CALCULATION PERFORMED UNDER (B) OF THIS SUBSECTION PRODUCES AN AMOUNT THAT IS GREATER THAN 5 PERCENT OF THE AMOUNT OF THE TOTAL EARNED PREMIUM AS CALCULATED UNDER (B) OF THIS SUBSECTION, THE AMOUNT THAT IS SO GREATER SHALL BE REFUNDED BY THE INSURER TO ITS POLICYHOLDERS OF RECORD AS OF AUGUST 15 OF THAT YEAR. SUCH REFUND CAN BE MADE EITHER BY PAYMENT OR AS A CREDIT TO BE APPLIED ON THE POLICYHOLDER'S ACCOUNT. THE TOTAL AMOUNT TO BE REFUNDED IS TO BE DISTRIBUTED AMONG AN INSURER'S POLICYHOLDERS IN A MANNER THAT REASONABLY TAKES INTO CONSIDERATION THE TOTAL AMOUNT OF THE PREMIUM CHARGE FOR THEIR THEN CURRENT POLICY. HOWEVER, THE AMOUNT OF ANY TOTAL REFUND PAID BY THE INSURER FOR THE TWO ACCIDENT YEARS PRIOR TO THE LATEST ACCIDENT YEAR IS TO BE SUBTRACTED FROM THE AMOUNT OF REFUND FOUND TO BE REQUIRED FOR THE YEAR THEN UNDER CONSIDERATION IN ORDER TO DETERMINE THE ACTUAL AMOUNT TO BE REFUNDED UNDER THIS SUBSECTION.

Subsection 3(D) AN INSURER SHALL REPORT TO THE COMMISSIONER WHAT ITS TOTAL REFUND OBLIGATION, IF ANY, IS FOR EACH YEAR IN A MANNER AND AT A TIME THAT THE COMMISSIONER MAY REASONABLY PRESCRIBE.

Subsection 3(E) IF AN INSURER CAN DEMONSTRATE TO THE COMMISSIONER THAT A REFUND REQUIREMENT UNDER (C) OF THIS SUBSECTION WILL IMPAIR ITS ABILITY TO EARN A FAIR RATE OF RETURN ON ITS AUTOMOBILE INSURANCE BUSINESS IN MICHIGAN, IT MAY APPLY TO THE COMMISSIONER FOR RELIEF FROM THE REQUIREMENT ONLY TO THE EXTENT NECESSARY TO AVOID THE IMPAIRMENT AND THE COMMISSIONER SHALL GRANT THE RELIEF THAT IS FOUND TO BE WARRANTED.

SECTION 3009

Section 3009 of Chapter 30 of the Michigan Insurance Laws is hereby amended so as to add to subsection (1) thereof the provision set forth in capital letters hereafter as a part of subsection (1).

Subsection (1) EXCEPT TO THE EXTENT OF A WAIVER MADE PURSUANT TO SECTION 3101(1) OF CHAPTER 31, an automobile liability or motor vehicle liability policy insuring against loss resulting from liability imposed by law for property damage, bodily injury, or death suffered by any person arising out of the ownership, maintenance, or use of a motor vehicle shall not be delivered or issued for delivery in this state with respect to any motor vehicle registered or principally garaged in this state unless the liability coverage is subject to a limit, exclusive of interest and costs, of not less than $20,000.00 because of bodily injury to or death of 1 person in any 1 accident, and subject to that limit for 1 person, to a limit of not less than $40,000.00 because of bodily injury to or death of 2 or more persons in any 1 accident, and to a limit of not less than $10,000.00 because of injury to or destruction of property of others in any accident.

SECTION 3010

Section 3010 is hereby to be enacted as a part of Chapter 30 of the Michigan Insurance Laws and is set forth in capital letters hereafter in its entirety.

Subsection 3010(1) ON AND AFTER APRIL 1, 1993 AN AUTOMOBILE LIABILITY OR MOTOR VEHICLE LIABILITY POLICY INSURING AGAINST LOSS RESULTING FROM LIABILITY IMPOSED BY LAW FOR BODILY INJURY OR DEATH SUSTAINED BY ANY PERSON THAT ARISES OUT OF THE OWNERSHIP, MAINTENANCE OR USE OF A MOTOR VEHICLE REGISTERED OR PRINCIPALLY GARAGED IN THIS STATE, INCLUDING ANY POLICY SUBJECT TO A WAIVER OF RESIDUAL LIABILITY INSURANCE UNDER SECTION 3101(1) OF CHAPTER 31, UPON BEING FIRST ISSUED OR RENEWED, SHALL INCLUDE FOR A CHARGE COVERAGE THAT COMPENSATES THOSE PERSONS ENTITLED TO IT FOR DAMAGES THEY ARE LEGALLY ENTITLED TO RECOVER FOR BODILY INJURY OR DEATH FROM OWNERS OR OPERATORS OF MOTOR VEHICLES THAT ARE NOT INSURED OR SECURED FOR LIABILITY PROTECTION FOR SUCH DAMAGES, INCLUDING OWNERS OR OPERATORS INSURED BY AN INSOLVENT INSURER, UNLESS THE POLICY PURCHASER REJECTS SUCH COVERAGE IN WRITING. THE COVERAGE TO BE SO PROVIDED SHALL HAVE A LIMIT AT LEAST EQUAL TO THE LIMIT AMOUNT FOR LIABILITY COVERAGE PROVIDED FOR IN SECTION 3009(1) OF THIS CHAPTER, THOUGH THE INSURER AND POLICY PURCHASER MAY AGREE ON A HIGHER LIMIT OF COVERAGE IF THEY BOTH SO PREFER.

Subsection (2) THOSE PERSONS ENTITLED TO THE COVERAGE TO BE PROVIDED PURSUANT TO SUBSECTION (1) SHALL AT LEAST INCLUDE ANY NAMED INSURED, HIS OR HER SPOUSE IF LIVING TOGETHER, A RESIDENT RELATIVE OF EITHER, AND ANY OTHER PERMISSIVE USER OR OCCUPANT OF THE MOTOR VEHICLE ON WHICH THE POLICY WAS ISSUED IF SUCH VEHICLE WAS INVOLVED IN THE OCCURRENCE FROM WHICH THE DAMAGES AROSE.

Subsection (3) A REJECTION OF THE COVERAGE DESCRIBED IN SUBSECTION (1) SHALL BE ON A FORM APPROVED BY THE COMMISSIONER WHICH EXPLAINS TO THE POLICY PURCHASER WHAT THE COVERAGE IS AND INFORMS THE PURCHASER THAT THE COVERAGE CAN BE REJECTED IN WRITING IF IT IS NOT WANTED. A NEW POLICY PURCHASER SHALL BE PROVIDED WITH SUCH A FORM AT THE TIME WHEN THE POLICY IS APPLIED FOR AND THE FORM SHALL BE SENT TO EXISTING POLICYHOLDERS ONLY AT THE TIME WHEN THEY ARE FIRST OFFERED RENEWAL ON OR AFTER APRIL 1, 1993.

Subsection (4) IN THE EVENT THE COVERAGE TO BE PROVIDED PURSUANT TO SUBSECTION (1) CAN BE OBTAINED UNDER THE TERMS AND PROVISIONS OF MORE THAN ONE APPLICABLE POLICY OR BECAUSE SUCH COVERAGE IS PROVIDED FOR MORE THAN ONE MOTOR VEHICLE BEING INSURED UNDER AN APPLICABLE POLICY, THIS COVERAGE NEED ONLY BE PROVIDED UNDER THIS SECTION SO AS TO PERMIT A RECOVERY OF DAMAGES UP TO THE EXTENT OF THE HIGHEST APPLICABLE LIMIT AVAILABLE UNDER ANY ONE POLICY OR COVERAGE, AND POLICY TERMS AND PROVISIONS MAY BE INCLUDED IN THE COVERAGE TO EFFECT THIS RESULT AND TO DISTRIBUTE THE OBLIGATION INVOLVED BETWEEN THE INSURERS THAT HAVE IT AS THEIR POLICIES MAY PROVIDE. THIS COVERAGE NEED NOT BE PROVIDED SO AS TO BE APPLICABLE WHEN ANY NAMED INSURED, HIS OR HER SPOUSE WHEN LIVING TOGETHER, OR A RESIDENT RELATIVE OF EITHER IS USING OR OCCUPYING A MOTOR VEHICLE OTHER THAN THE VEHICLE ON WHICH THE COVERAGE WAS ISSUED AT THE TIME OF THE OCCURRENCE FROM WHICH THE DAMAGES AROSE, IF THE VEHICLE BEING USED OR OCCUPIED IS INSURED WITH COVERAGE COMPLYING WITH THIS SECTION.

SECTION 3101

Section 3101 of Chapter 31 of the Michigan Insurance Laws is hereby amended so as to add to subsection (1) thereof the provisions set forth in capital letters hereafter as a part of subsection (1), and add as subsections (5) and (6) thereof the provisions set forth hereafter as subsections (5) and (6).

Subsection (1) The owner or registrant of a motor vehicle required to be registered in this state shall maintain security for payment of benefits under personal protection insurance IN AN AMOUNT NOT LESS THAN THE LIMIT FOR ALLOWABLE EXPENSES SET FORTH IN SECTION 3107 (1)(a)(i), property protection insurance, and residual liability insurance. HOWEVER, THE REQUIREMENT OF RESIDUAL LIABILITY INSURANCE, WITH RESPECT TO ACCIDENTS OCCURRING WITHIN THIS STATE AND NOT ELSEWHERE ON AND AFTER APRIL 1, 1993, MAY BE WAIVED IN WRITING BY A POLICY PURCHASER ON A FORM APPROVED BY THE COMMISSIONER THAT REASONABLY EXPLAINS THE EFFECT OF THE WAIVER AND THE APPROXIMATE COST OF PURCHASING COVERAGE WITHOUT THE WAIVER WITH LIMITS IN THE AMOUNT THAT WOULD OTHERWISE BE REQUIRED BY SECTION 3009(1) OF CHAPTER 30. Security shall only be required to be in effect during the period the motor vehicle is driven or moved upon a highway. Notwithstanding any other provision in this act, an insurer that has issued an automobile insurance policy on a motor vehicle that is not driven or moved upon a highway may allow the insured owner or registrant of the motor vehicle OR THE POLICY PURCHASER to delete a portion of the coverages under the policy and maintain the comprehensive coverage portion of the policy in effect.

Subsection (5) A WAIVER OF RESIDUAL LIABILITY INSURANCE WHEN MADE PURSUANT TO SUBSECTION (1) SHALL

(A) APPLY TO ALL PERSONS THAT WOULD HAVE BEEN INSURED UNDER THE POLICY WITHOUT THE WAIVER.

(B) CONTINUE TO BE IN EFFECT FOR ANY RENEWAL, REINSTATEMENT, SUBSTITUTION, TRANSFER, MODIFICATION, AMENDMENT OR REPLACEMENT OF THE POLICY ON WHICH THE WAIVER WAS MADE UNTIL THE POLICY PURCHASER NOTIFIES THE INSURER IN WRITING ON A FORM PROVIDED BY THE INSURER THAT THE WAIVER PREVIOUSLY MADE IS TO BE DISCONTINUED AND THAT COVERAGE IS TO BE RESTORED WITHOUT A WAIVER AND WITH A SPECIFIED LIMIT.

Subsection (6) THERE SHALL BE NO LIABILITY IMPOSED AGAINST, AND NO CAUSE OF ACTION OF ANY NATURE SHALL ARISE AGAINST, AN INSURER OR AN INSURER'S AGENT, SOLICITOR, EMPLOYEE, OFFICER OR DIRECTOR BASED UPON OR RELATED TO A WAIVER OF RESIDUAL LIABILITY INSURANCE COVERAGE PURSUANT TO SUBSECTION (1) EXCEPT THAT WHICH IS BASED ON FRAUD OR MISREPRESENTATION.

SECTION 3104

Section 3104 of Chapter 31 of the Michigan Insurance Laws is hereby amended so as to add to subsection (7)(d) thereof the provisions set forth in capital letters hereafter as a part of subsection (7)(d).

Subsection (7)(d) In a manner provided for in the plan of operation, calculate and charge to members of the Association a total premium sufficient to cover the losses and expenses of the Association which the Association will likely incur during the period for which the premium is applicable. The premium shall include an amount to cover incurred but not reported losses for the period and may be adjusted for any excess or deficient premiums from previous periods. Excesses or deficiencies from previous periods may be fully adjusted in a single period or may be adjusted over several periods in a manner provided for in the plan of operation, EXCEPT THAT ANY ADJUSTMENT FOR DEFICIENCIES SHALL NOT EXCEED AN AMOUNT OF 100 MILLION DOLLARS, OR 12 PERCENT OF THE TOTAL DEFICIENCY EXISTING AT THE TIME OF THE ADJUSTMENT, WHICHEVER IS GREATER, FOR ANY ONE YEAR. Each member shall be charged an amount equal to that member's total earned car years of insurance providing the security required by section 3101(1) or 3103(1), or both, written in this state during the period to which the premium applies, multiplied by the average premium per car, AND THE AMOUNT CHARGED SHALL BE ADJUSTED TO REFLECT DIFFERENCES IN THE PERCENTAGE OF A MEMBER'S INSUREDS WHO SELECT AN OPTIONAL LIMIT AMOUNT FOR ALLOWABLE EXPENSES PURSUANT TO SECTION 3107(1)(a)(ii) AS WELL AS THE OPTIONAL LIMIT AMOUNT THEY SELECT. The average premium per car shall be the total premium calculated divided by the total earned car years of insurance providing the security required by section 3101(1) or 3103(1) written in this state of all members during the period to which the premium applies. As used in this subdivision, "car" includes a motorcycle.

SECTION 3107

Section 3107 of Chapter 31 of the Michigan Insurance Laws is hereby amended so as to add to subsection (1)(a) thereof the provisions set forth in capital letters hereafter as a part of subsection (1)(a), including (1)(a)(i) and (1)(a)(ii); and add as subsections (3), (4), and (5) thereof the provisions set forth hereafter as 3107 (3), 3107(4), and 3107(5).

Subsection 3107(1)(a) Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services, and accommodations for an injured person's care, recovery, or rehabilitation UP TO THE LIMITS AND TO THE EXTENT PROVIDED FOR IN EITHER SUBPARAGRAPHS (i) OR (ii), WHICHEVER IS APPLICABLE TO THE INJURED PERSON. Allowable expenses within personal protection insurance coverage shall not include charges for a hospital room in excess of a reasonable and customary charge for semiprivate accommodations except if the injured person requires special or intensive care, or for funeral and burial expenses in the amount set forth in the policy which shall not be less than $1,750.00 or more than $5,000.00.

(i) A LIMIT OF $250,000 TO BE PROVIDED ON A PER INDIVIDUAL PER LOSS OCCURRENCE BASIS FOR THE PERSON NAMED IN THE POLICY, THE SPOUSE OF THAT PERSON, ANY RELATIVE OF EITHER DOMICILED IN THE SAME HOUSEHOLD, AND ANY OTHER PERSON ENTITLED TO RECEIVE PERSONAL PROTECTION INSURANCE BENEFITS UNDER THE POLICY.

(ii) A LIMIT OF EITHER $500,000, $750,000, $1,000,000, $2,000,000, $3,000,000, $4,000,000 OR $5,000,000, AS SELECTED IN WRITING BY THE PURCHASER OF THE POLICY TO BE PROVIDED ON A PER INDIVIDUAL PER LOSS OCCURRENCE BASIS FOR ONLY THE PERSON NAMED IN THE POLICY, THE SPOUSE OF THAT PERSON, AND ANY RELATIVE OF EITHER DOMICILED IN THE SAME HOUSEHOLD.

3107(3) ON A FORM APPROVED BY THE COMMISSIONER, AN INSURER OF PERSONAL PROTECTION INSURANCE BENEFITS SHALL PROVIDE ITS NEW POLICY PURCHASERS, AND ITS RENEWAL POLICY PURCHASERS AT THE TIME OF THE FIRST RENEWAL FOLLOWING THE EFFECTIVE DATE OF THIS PROVISION, WITH AN OPPORTUNITY TO SELECT EITHER THE LIMIT FOR ALLOWABLE EXPENSES SET FORTH IN (1)(a)(i) OR ONE OF THE OPTIONAL LIMIT AMOUNTS FOR ALLOWABLE EXPENSES SET FORTH IN (1)(a)(ii). IF THE PURCHASER DOES NOT SELECT AN OPTIONAL LIMIT AMOUNT OR FAILS TO DO SO BY RETURNING THE FORM WITH THE SELECTION INDICATED ON IT ON OR BEFORE POLICY RENEWAL, COVERAGE UNDER THE POLICY FOR ALLOWABLE EXPENSES WILL BE AS PROVIDED FOR IN (1)(a)(i) AND WILL CONTINUE TO BE AS PROVIDED FOR THEREIN UNTIL THE PURCHASER NOTIFIES THE INSURER IN WRITING ON THE APPROVED FORM THAT COVERAGE IN A SPECIFIED OPTIONAL LIMIT AMOUNT IS DESIRED INSTEAD.

3107(4) ALLOWABLE EXPENSES SHALL NOT EXCEED THE MAXIMUM AMOUNT A HEALTH CARE FACILITY OR PROVIDER IS ENTITLED TO BE PAID OR REIMBURSED FOR TREATMENT, SERVICE, ACCOMMODATION, AND MEDICATION PURSUANT TO THE FEE SCHEDULES CONTAINED IN R418.101 to R418.2324 OF THE MICHIGAN ADMINISTRATIVE CODE. THE COMMISSIONER SHALL, AS SOON AS PRACTICAL, DEVELOP RULES TO ESTABLISH SCHEDULES OF MAXIMUM FEES OR CHARGES FOR USE UNDER THIS SUBSECTION WHICH SHALL NOT EXCEED THE MAXIMUM FEES OR CHARGES ESTABLISHED IN R418.101 TO R418.2324 AND MAY ADJUST HIS OR HER OWN SCHEDULES FROM TIME TO TIME AS MAY BE REQUIRED.

3107(5) THERE SHALL BE NO LIABILITY IMPOSED AGAINST, AND NO CAUSE OF ACTION OF ANY NATURE SHALL ARISE AGAINST, AN INSURER OR AN INSURER'S AGENT, SOLICITOR, EMPLOYEE, OFFICER OR DIRECTOR BASED UPON OR RELATED TO THE LIMIT FOR ALLOWABLE EXPENSES PROVIDED FOR UNDER A POLICY EXCEPT THAT WHICH IS BASED ON FRAUD OR MISREPRESENTATION.

SECTION 3109a

Section 3109a of Chapter 31 of the Michigan Insurance Laws is hereby amended by substituting for the provision now in effect the provisions set forth in capital letters hereafter as 3109a(1), (2), and (3).

Section 3109a ~~An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. The deductibles and exclusions required to be offered by this section shall be subject to prior approval by the Commissioner and shall apply only to benefits payable to the person named in the policy, the spouse of the insured and any relative of either domiciled in the same household.~~

Section 3109a(1) AN INSURER OF PERSONAL PROTECTION INSURANCE BENEFITS NEED ONLY PROVIDE COVERAGE FOR THOSE BENEFITS UNDER ITS POLICY TO AN EXTENT THAT WILL REASONABLY RELATE TO OTHER HEALTH, ACCIDENT OR DISABILITY COVERAGE OR PROTECTION AVAILABLE TO ITS POLICY PURCHASER, AND A PERSON REQUIRED TO MAINTAIN SECURITY FOR PAYMENT OF SUCH BENEFITS UNDER SECTION 3101 MAY SATISFY THAT OBLIGATION THROUGH ALL AVAILABLE SOURCES OF COVERAGE OR PROTECTION. AN INSURER MAY IMPLEMENT THE DEGREE OF PROTECTION IT WILL PROVIDE UNDER ITS POLICY IN RELIANCE UPON THIS SECTION THROUGH THE USE OF SUITABLE DEDUCTIBLE AND EXCLUSION PROVISIONS. IN LIMITING COVERAGE FOR PERSONAL PROTECTION INSURANCE BENEFITS PURSUANT TO THIS SECTION AN INSURER WILL APPROPRIATELY LOWER ITS PREMIUM RATES FOR THE REDUCED COVERAGE IT WILL PROVIDE, AND IT NEED NOT PAY OR PROVIDE ANY BENEFITS UNDER SUCH COVERAGE TO ANY PERSON CLAIMING BENEFITS THEREUNDER THAT ARE AVAILABLE OR COULD BE OBTAINED FROM OTHER SOURCES OF COVERAGE OR PROTECTION, WHETHER UTILIZED OR NOT.

(2) AN INSURER SHALL NOT ISSUE A POLICY PROVIDING REDUCED COVERAGE FOR PERSONAL PROTECTION INSURANCE BENEFITS AT A LOWER PREMIUM RATE TO ANY PURCHASER THAT CANNOT ESTABLISH TO ITS REASONABLE SATISFACTION THAT THERE IS AVAILABLE TO HIM OR HER, AND THE SPOUSE AND DEPENDENT CHILDREN OF EITHER WHO ARE DOMICILED IN THE SAME HOUSEHOLD, OTHER SOURCES OF BENEFIT PAYMENT OR PROTECTION THAT ARE REASONABLY RELATED TO THE TYPE OF REDUCED COVERAGE THAT WOULD BE ISSUED BY THE INSURER.

(3) A POLICY PURCHASER IS REQUIRED TO MAKE REASONABLE DISCLOSURE TO THE INSURER OF INFORMATION PERTAINING TO THE AVAILABILITY OF OTHER SOURCES OF COVERAGE OR PROTECTION.

SECTION 3111

Section 3111 of Chapter 31 of the Michigan Insurance Laws is hereby amended so as to add to it the provisions set forth in capital letters hereafter as a part of section 3111.

Section 3111 Personal protection insurance benefits are payable for accidental bodily injury suffered in an accident occurring out of this state, if the accident occurs within the United States, its territories and possessions, or in Canada, and the person whose injury is the basis of the claim was at the time of the accident a named insured under a personal protection insurance policy, his OR HER spouse, a relative of either domiciled in the same household, or an occupant of a vehicle involved in the accident, IF THAT PERSON IS A RESIDENT OF MICHIGAN AT THE TIME OF THE ACCIDENT, whose owner or registrant was insured under a personal protection insurance policy or has provided security approved by the secretary of state under subsection (4) of section 3101.

SECTION 3115

Section 3115 of Chapter 31 of the Michigan Insurance Laws is hereby amended so as to add to subsection 3 thereof the provision set forth in capital letters hereafter as a part of subsection 3, and add as subsection (4) thereof the provision set forth hereafter as subsection 4.

Section 3115(3) A limit upon the amount of personal protection insurance benefits available because of accidental bodily injury to 1 person arising from 1 motor vehicle accident shall be determined without regard to the number of policies applicable to the accident OR THE NUMBER OF VEHICLES INSURED UNDER ANY 1 POLICY.

Section 3115(4) IF AN INJURED PERSON WOULD HAVE COVERAGE FOR PERSONAL PROTECTION INSURANCE BENEFITS UNDER MORE THAN 1 POLICY, THE MAXIMUM RECOVERY OF BENEFITS OBTAINABLE SHALL NOT EXCEED THE AMOUNT THAT WOULD BE RECOVERABLE UNDER THE POLICY THAT PROVIDES THE HIGHEST DOLLAR LIMIT OF BENEFITS.

SECTION 3135

Section 3135 of Chapter 31 of the Michigan Insurance Laws is hereby amended so as to add to subsection (1) thereof the provisions set forth in capital letters hereafter as a part of subsection (1), including (1)(a) and (1)(b).

Subsection 3135(1) A person remains subject to tort liability for noneconomic loss caused by his or her ownership, maintenance, or use of a motor vehicle only if the injured person has suffered death, serious impairment of body function, or permanent serious disfigurement. FOR A CAUSE OF ACTION FOR TORT LIABILITY ARISING ON AND AFTER APRIL 1, 1993,

(A) AN INJURED PERSON SHALL NOT HAVE SUFFERED SERIOUS IMPAIRMENT OF BODY FUNCTION UNLESS THE PERSON HAS SUFFERED AN OBJECTIVELY MANIFESTED IMPAIRMENT OF AN IMPORTANT BODY FUNCTION THAT AFFECTS HIS OR HER GENERAL ABILITY TO LEAD A NORMAL LIFE.

(B) DAMAGES SHALL BE ASSESSED ON THE BASIS OF COMPARATIVE FAULT, BUT LIABILITY SHALL NOT BE AWARDED IN FAVOR OF A PARTY WHO IS MORE THAN 50% AT FAULT IN THE OCCURRENCE.

ADDENDUM 3

1994
Proposal C

STATE OF MICHIGAN
87TH LEGISLATURE
REGULAR SESSION OF 1993

Introduced by Reps. Griffin, Martin, Baade, Llewellyn, Hoffman, Byrum, Varga, Porreca, Middaugh, DeMars, Oxender, Agee, Kukuk, Wetters, Bobier, Harder, Dalman, Shepich, Nye, Stallworth, DeLange, Weeks, Brackenridge, Bandstra, Bender, Gnodtke, Hammerstrom, Horton, Richard A. Young, Randall, Middleton, Alley, Voorhees, Fitzgerald, Shugars, London, Gernaat, Olshove, Stille, Sikkema, McBryde, Dolan, Kaza, Hill, Goschka, McNutt, Lowe, Bullard, Vorva, Jamian, Rhead, Walberg, Cropsey, Crissman, Galloway, McManus, Bodem, Johnson, Bankes, Gilmer, Bryant, Dobb, Munsell, Jaye, Gustafson and Rocca

ENROLLED HOUSE BILL No. 4156

AN ACT to amend the title and sections 2103, 2110, 2111, 2118, 2120, 3037, 3101, 3101a, 3104, 3107, 3109a, 3115, 3116, 3135, 3142, 3145, 3157, 3172, 3320, 3330, 3340, 3355, and 7911 of Act No. 218 of the Public Acts of 1956, entitled as amended "An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state and to facilitate the

purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to repeal certain acts and parts of acts; to repeal certain acts and parts of acts on specific dates; to repeal certain parts of this act on specific dates; and to provide penalties for the violation of this act," section 2103 as amended by Act No. 305 of the Public Acts of 1990, sections 2111 and 3107 as amended by Act No. 191 of the Public Acts of 1991, section 2118 as amended by Act No. 43 of the Public Acts of 1988, section 2120 as amended by Act No. 350 of the Public Acts of 1984, sections 3037 and 3320 as amended and section 3101a as added by Act No. 461 of the Public Acts of 1980, section 3101 as amended by Act No. 126 of the Public Acts of 1988, section 3104 as amended by Act No. 445 of the Public Acts of 1980, section 3172 as amended by Act No. 426 of the Public Acts of 1984, section 3340 as amended by Act No. 10 of the Public Acts of 1986, and section 7911 as amended by Act No. 137 of the Public Acts of 1990, being sections 500.2103, 500.2110, 500.2111, 500.2118, 500.2120, 500.3037, 500.3101, 500.3101a, 500.3104, 500.3107, 500.3109a, 500.3115, 500.3116, 500.3135, 500.3142, 500.3145, 500.3157, 500.3172, 500.3320, 500.3330, 500.3340, 500.3355, and 500.7911 of the Michigan Compiled Laws; and to add sections 2106a, 2106b, 2106c, 2109a, 2110a, 2111b, 2111f, 2111g, 2111h, 2112a, 2115a, 2115b, 2115c, 2115d, 2115e, 2134, 2136, 2138, 2140, 3015, 3103a, 3104a, 3104b, 3118, and 3172a and chapter 32a.

The People of the State of Michigan enact:

Section 1. The title and sections 2103, 2110, 2111, 2118, 2120, 3037, 3101, 3101a, 3104, 3107, 3109a, 3115, 3116, 3135, 3142, 3145, 3157, 3172, 3320, 3330, 3340, 3355, and 7911 of Act No. 218 of the Public Acts of 1956, section 2103 as amended by Act No. 305 of the Public Acts of 1990, sections 2111 and 3107 as amended by Act No. 191 of the Public Acts of 1991, section 2118 as amended by Act No. 43 of the Public Acts of 1988, section 2120 as amended by Act No. 350 of the Public Acts of 1984, sections 3037 and 3320 as amended and section 3101a as added by Act No. 461 of the Public Acts of 1980, section 3101 as amended by Act No. 126 of the Public Acts of 1988, section 3104 as amended by Act No. 445 of the Public Acts of 1980, section 3172 as amended by Act No. 426 of the Public Acts of 1984, section 3340 as amended by Act No. 10 of the Public Acts of 1986, and section 7911 as amended by Act No. 137 of the Public Acts of 1990, being sections 500.2103, 500.2110, 500.2111, 500.2118, 500.2120, 500.3037, 500.3101, 500.3101a, 500.3104, 500.3107, 500.3109a, 500.3115, 500.3116, 500.3135, 500.3142, 500.3145, 500.3157, 500.3172, 500.3320, 500.3330, 500.3340, 500.3355, and 500.7911 of the Michigan Compiled Laws, are amended and sections 2106a, 2106b, 2106c, 2109a, 2110a, 2111b, 2111f, 2111g, 2111h, 2112a, 2115a, 2115b, 2115c, 2115d, 2115e, 2134, 2136, 2138, 2140, 3015, 3103a, 3104a, 3104b, 3118, and 3172a and chapter 32a are added to read as follows:

TITLE

An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state, to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates, and to provide for certain powers and duties, upon certain persons, as they affect the continued availability and affordability of that insurance; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain

assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain persons; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to provide an appropriation; to repeal certain acts and parts of acts; to repeal certain acts and parts of acts on specific dates; to repeal certain parts of this act on specific dates; and to provide penalties for the violation of this act.

Sec. 2103. (1) "Eligible person", for automobile insurance, means a person who is an owner or registrant of an automobile registered or to be registered in this state or who holds a valid Michigan license to operate a motor vehicle, but does not include any of the following:

(a) A person who is not required to maintain security pursuant to section 3101, unless the person intends to reside in this state for 30 days or more and makes a written statement of that intention on a form approved by the commissioner.

(b) A person whose license to operate a vehicle is under suspension or revocation.

(c) A person who has been convicted within the immediately preceding 5-year period of fraud or intent to defraud involving an insurance claim or an application for insurance; or an individual who has been successfully denied, within the immediately preceding 5-year period, payment by an insurer of a claim in excess of $1,000.00 under an automobile insurance policy, if there is evidence of fraud or intent to defraud involving an insurance claim or application.

(d) A person who, during the immediately preceding 3-year period, has been convicted under, or who has been subject to an order of disposition of the probate court for a violation of, any of the following:

(*i*) Section 324 of the Michigan penal code, Act No. 328 of the Public Acts of 1931, as amended, being section 750.324 of the Michigan Compiled Laws; section 1 of Act No. 214 of the Public Acts of 1931, being section 752.191 of the Michigan Compiled Laws; or under any other law of this state the violation of which constitutes a felony resulting from the operation of a motor vehicle.

(*ii*) Section 625 of the Michigan vehicle code, Act No. 300 of the Public Acts of 1949, as amended, being section 257.625 of the Michigan Compiled Laws.

(*iii*) Section 617, 617a, 618, or 619 of Act No. 300 of the Public Acts of 1949, as amended, being sections 257.617, 257.617a, 257.618, and 257.619 of the Michigan Compiled Laws.

(*iv*) Section 626 of Act No. 300 of the Public Acts of 1949, as amended, being section 257.626 of the Michigan Compiled Laws; or for a similar violation under the laws of any other state or a municipality within or without this state.

(e) A person whose vehicle insured or to be insured under the policy fails to meet the motor vehicle safety requirements of sections 683 to 711 of Act No. 300 of the Public Acts of 1949, as amended, being sections 257.683 to 257.711 of the Michigan Compiled Laws.

(f) A person whose policy of automobile insurance has been canceled because of nonpayment of premium or financed premium within the immediately preceding 2-year period, unless the premium due on a policy for which application has been made is paid in full before issuance or renewal of the policy.

(g) A person who fails to obtain or maintain membership in a club, group, or organization, if membership is a uniform requirement of the insurer as a condition of providing insurance, and if the dues, charges, or other conditions for membership are applied uniformly throughout this state, are not expressed as a percentage of premium, and do not vary with respect to the rating classification of the member except for the purpose of offering a membership fee to family units. Membership fees may vary in accordance with the amount or type of coverage if the purchase of additional coverage, either as to type or amount, is not a condition for reduction of dues or fees.

(h) A person whose driving record for the 3-year period immediately preceding application for or renewal of a policy, has, pursuant to section 2119a, an accumulation of more than 6 insurance eligibility points.

(2) "Eligible person", for home insurance, means a person who is the owner-occupant or tenant of a dwelling of any of the following types: a house, a condominium unit, a cooperative unit, a room, or an apartment; or a person who is the owner-occupant of a multiple unit dwelling of not more than 4 residential units. Eligible person does not include any of the following:

(a) A person who has been convicted, in the immediately preceding 5-year period, of 1 or more of the following:

(*i*) Arson, or conspiracy to commit arson.

(*ii*) A crime under sections 72 to 77, 112, 211a, 377a, 377b, or 380 of Act No. 328 of the Public Acts of 1931, as amended, being sections 750.72 to 750.77, 750.112, 750.211a, 750.377a, 750.377b, and 750.380 of the Michigan Compiled Laws.

(*iii*) A crime under section 92, 151, 157b, or 218 of Act No. 328 of the Public Acts of 1931, as amended, being sections 750.92, 750.151, 750.157b, and 750.218 of the Michigan Compiled Laws, based upon a crime described in subparagraph (*ii*) committed by or on behalf of the person.

(b) A person who has been successfully denied, within the immediately preceding 5-year period, payment by an insurer of a claim under a home insurance policy in excess of $2,000.00, based on evidence of arson, conspiracy to commit arson, misrepresentation, fraud, or conspiracy to commit fraud, committed by or on behalf of the person, if the amount of the denied claim was greater than any of the following:

(*i*) For a claim under a repair cost policy, 15% of the amount of insurance in force.

(*ii*) For a claim under a replacement cost policy, 10% of the amount of insurance in force.

(c) A person who insures or seeks to insure a dwelling that is being used for an illegal or demonstrably hazardous purpose.

(d) A person who refuses to purchase an amount of insurance equal to at least 80% of the replacement cost of the property insured or to be insured under a replacement cost policy.

(e) A person who refuses to purchase an amount of insurance equal to at least 100% of the market value of the property insured or to be insured under a repair cost policy.

(f) A person who refuses to purchase an amount of insurance equal to at least 100% of the actual cash value of the property insured or to be insured under a tenant or renter's home insurance policy.

(g) A person whose policy of home insurance has been canceled because of nonpayment of premium within the immediately preceding 2-year period, unless the premium due on the policy is paid in full before issuance or renewal of the policy.

(h) A person who insures or seeks to insure a dwelling, if the insured value is not any of the following:

(*i*) For a repair cost policy, at least $7,500.00.

(*ii*) For a replacement policy, at least $15,000.00 or another amount that the commissioner may establish biennially on and after January 1, 1983, pursuant to rules promulgated by the commissioner under the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.328 of the Michigan Compiled Laws, based upon changes in applicable construction cost indices.

(i) A person who insures or seeks to insure a dwelling that does not meet minimum standards of insurability as established by rules promulgated by the commissioner pursuant to Act No. 306 of the Public Acts of 1969, as amended.

(j) A person whose real property taxes with respect to the dwelling insured or to be insured have been and are delinquent for 2 or more years at the time of renewal of, or application for, home insurance.

(k) A person who has failed to procure or maintain membership in a club, group, or organization, if membership is a uniform requirement of the insurer and if the dues, charges, or other conditions for membership are applied uniformly throughout this state, are not expressed as a percentage of premium, and do not vary with respect to the rating classification of the member except for the purpose of offering a membership fee to family units. Membership fees may vary in accordance with the amount or type of coverage if the purchase of additional coverage, either as to type or amount, is not a condition for reduction of dues or fees.

(3) "Home insurance" means any of the following, but does not include insurance intended to insure commercial, industrial, professional, or business property, obligations, or liabilities:

(a) Fire insurance for an insured's dwelling of a type described in subsection (2).

(b) If contained in or indorsed to a fire insurance policy providing insurance for the insured's residence, other insurance intended primarily to insure nonbusiness property, obligations, and liabilities.

(c) Other insurance coverages for an insured's residence as prescribed by rule promulgated by the commissioner pursuant to Act No. 306 of the Public Acts of 1969, as amended. A rule proposed for promulgation by the commissioner pursuant to this section shall be transmitted in advance to each member of the standing committee in the house and in the senate that has jurisdiction over insurance.

(4) "Insurance eligibility points" means all of the following:

(a) Points calculated, according to the following schedule, for convictions, determinations of responsibility for civil infractions, or findings of responsibility in probate court:

(*i*) For a violation of a lawful speed limit by more than 15 miles per hour, or careless driving, 4 points.

(*ii*) For a violation of a lawful speed limit by more than 10 miles per hour, but less than 16 miles per hour, 3 points.

(*iii*) For a violation of a lawful speed limit by 10 miles per hour or less, 2 points.

(*iv*) For a violation of a speed limit by 15 miles per hour or less on a roadway which had a lawfully posted maximum speed of 70 miles per hour as of January 1, 1974, 2 points.

(*v*) For all other moving violations pertaining to the operation of motor vehicles, 2 points.

(b) Points calculated, according to the following schedule, for determinations that the person was substantially at-fault, as defined in section 2104(4):

(*i*) For the first substantially at-fault accident, 3 points.

(*ii*) For the second and each subsequent substantially at-fault accident, 4 points.

(5) "Insurer" means an insurer authorized to transact in this state the kind or combination of kinds of insurance constituting automobile insurance or home insurance, as defined in this chapter.

Sec. 2106a. (1) The commissioner shall develop by October 1, 1993 a standard rate filing form for private passenger nonfleet automobile insurance. By December 1, 1993, each automobile insurer shall use the standard rate filing form when filing a rate with the commissioner for private passenger nonfleet automobile insurance.

(2) With each rate filing, an automobile insurer shall complete and submit to the commissioner a buyer's guide rate survey on a form prepared by the commissioner that the commissioner can use in complying with section 2115c.

Sec. 2106b. (1) The commissioner shall develop by October 1, 1993 a standard application form in plain English for private passenger nonfleet automobile insurance. The application form shall list what coverages are mandatory and what are not and shall indicate how to obtain consumer assistance materials. By December 1, 1993, each automobile insurer shall accept the standard application form for private passenger nonfleet automobile insurance. After April 1, 1994, an automobile insurer shall use an application form substantially similar to the standard application form for private passenger nonfleet automobile insurance.

(2) An electronically or electromagnetically transmitted facsimile of the automobile insurance application form may be sent to an applicant. A signed electronically or electromagnetically transmitted facsimile of the automobile insurance application form shall be treated the same as an original signed automobile insurance application form.

(3) The commissioner shall have copies of the standard application form available to the general public and shall provide copies of the standard application form to the secretary of state branch offices for distribution to the public.

(4) When applying for coverage through an insurer exclusively represented by duly licensed agents, members of the general public shall submit either the standard application form or the insurer's own application form to any insurance agent appointed by that insurer.

Sec. 2106c. (1) The commissioner shall develop by October 1, 1993 a model declarations page in plain English for private passenger nonfleet automobile insurance. By December 1, 1993, each automobile insurer shall use a declarations page substantially similar to the model declarations page developed by the commissioner for private passenger nonfleet automobile insurance.

(2) The commissioner shall provide that the model declarations page contain at least the following notice concerning comprehensive and collision coverages:

Warning. Comprehensive and collision coverages reimburse only for the current value of your motor vehicle less your deductible.

(3) If an automobile insurer lists assessments authorized or permitted by law on its declaration page, the insurer shall include only the actual cost of the assessments and shall not include or list any administrative or other fees within the assessments.

Sec. 2109a. (1) As used in this section:

(a) "Loss ratio" means incurred losses and loss adjustment expenses expressed as a percentage of earned premiums.

(b) "Substantially uniform" means the absence of significant variations among loss ratios.

(2) By not later than 120 days after the effective date of the amendatory act that added this section, an insurer's automobile insurance rates for all classes and coverages for each of its rating territories shall be established in a manner that can reasonably be anticipated to produce loss ratios that are substantially uniform on an average basis over a 3-year period.

Sec. 2110. (1) In developing and evaluating rates pursuant to the standards prescribed in sections 2109 and 2109a, due consideration shall be given to past and prospective loss experience within and outside this state, to catastrophe hazards, if any; to a reasonable margin for underwriting profit and contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers; to past and prospective expenses, both countrywide and those specially applicable to this state exclusive of assessments under this act; to assessments under this act; to underwriting practice and judgment; and to all other relevant factors within and

outside this state. In determining the reasonableness of rates for automobile insurance, consideration shall be given to expenses, investment income earned on loss reserves, investment income earned on unearned premium reserves, and investment income earned on that portion of capital and surplus attributable to automobile insurance, as well as the factors used to determine the amount of the reserves.

(2) The systems of expense provisions included in the rates for use by an insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of the insurer or group with respect to any kind of insurance or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable.

(3) Risks may be grouped by classifications for the establishment of rates and minimum premiums. The classifications shall measure differences in losses, expenses, or both.

Sec. 2110a. (1) By not later than 300 days after the effective date of the amendatory act that added this section, an automobile insurer shall establish and maintain a premium discount plan for personal protection insurance that provides for a premium discount if a motor vehicle has 1 or more of the following safety features:

(a) Antilacerative glass.

(b) Air bags.

(c) Antilock brakes.

(d) Enhanced sidewall protection.

(e) Bumpers that exceed a collision standard of 5 miles per hour.

(f) Other passive safety features that reduce frequency or severity of collisions or injuries as determined by the insurer and approved by the commissioner.

(2) A premium discount plan required under this section may require the insured individual to certify in writing that he or she has 1 or more of the safety features listed in subsection (1) as a condition to receiving the premium discount. If an insured receives a premium discount after providing this certification and sustains a loss while operating that motor vehicle and it does not have the safety features that were certified to, an insurer may impose a $500.00 deductible with respect to that loss in addition to any deductible provided in the policy and may subsequently deny to the insured the right to participate in any premium discount plan established by the insurer pursuant to this section for a period of 12 months.

Sec. 2111. (1) Notwithstanding any provision of this act and this chapter to the contrary, classifications and territorial base rates used by any insurer in this state with respect to automobile insurance or home insurance shall conform to the applicable requirements of this section.

(2) Classifications established pursuant to this section for automobile insurance shall be based only upon 1 or more of the following factors, which shall be applied by an insurer on a uniform basis throughout the state:

(a) With respect to all automobile insurance coverages:

(*i*) The age of the driver.

(*ii*) The length of driving experience.

(*iii*) The number of years licensed to operate a motor vehicle.

(*iv*) Driver primacy, based upon the proportionate use of each vehicle insured under the policy by individual drivers insured or to be insured under the policy.

(*v*) Average miles driven weekly, annually, or both.

(*vi*) Type of use, such as business, farm, or pleasure use.

(*vii*) Vehicle design and equipment characteristics including standard features and options, grouped together as much as practicable by vehicle make and model, that bear upon the ability of the vehicle to protect passengers from injury or to avoid accidents.

(*viii*) Daily or weekly commuting mileage.

(*ix*) Number of cars insured by the insurer or number of licensed operators in the household. However, number of licensed operators shall not be used as an indirect measure of marital status.

(*x*) Amount of insurance.

(*xi*) Deductibles.

(*xii*) Characteristics of vehicle usage that have a demonstrable relationship to severity or frequency of accidents. These characteristics may include conditions of customary or frequent vehicle use such as time of day, density of traffic and other driving conditions, and accident frequency and severity in use zones or areas where the insured vehicle is customarily or frequently driven by the insured or members of the insured's household.

(b) In addition to the factors prescribed in subdivision (a), with respect to personal protection insurance coverage:

(*i*) Earned income.

(*ii*) Number of dependents of income earners insured under the policy.

(*iii*) Coordination of benefits.

(*iv*) Use of a safety belt.

(c) In addition to the factors prescribed in subdivision (a), with respect to collision and comprehensive coverages:

(*i*) The anticipated cost of vehicle repairs or replacement, which may be measured by age, price, cost new, or value of the insured automobile, and other factors directly relating to that anticipated cost.

(*ii*) Vehicle make and model.

(*iii*) Vehicle design characteristics related to vehicle damageability.

(*iv*) Vehicle design and equipment characteristics including standard features and options by vehicle make and model and that bear upon the vehicle's ability to avoid accidents, the vehicle's resistance to damage, and the cost of repair of a damaged vehicle. On and after January 1, 1994, an insurer is required to base its rating system for collision coverage upon and to quote collision coverage upon the characteristics in this subparagraph.

(*v*) Vehicle characteristics relating to automobile theft prevention devices.

(d) In addition to the factors prescribed in subdivisions (a) and (c) with respect to comprehensive coverages only:

(*i*) The presence of passive theft prevention devices on the insured vehicle.

(*ii*) Conditions under which the vehicle is garaged or parked that relate to the risk of loss from hazards insured against.

(e) With respect to all automobile insurance coverage other than comprehensive, successful completion by the individual driver or drivers insured under the policy of an accident prevention education course that meets the following criteria:

(*i*) The course shall include a minimum of 8 hours of classroom instruction.

(*ii*) The course shall include, but not be limited to, a review of all of the following:

(A) The effects of aging on driving behavior.

(B) The shapes, colors, and types of road signs.

(C) The effects of alcohol and medication on driving.

(D) The laws relating to the proper use of a motor vehicle.

(E) Accident prevention measures.

(F) The benefits of safety belts and child restraints.

(G) Major driving hazards.

(H) Interaction with other highway users such as motorcyclists, bicyclists, and pedestrians.

(I) Limits and benefits of the various automobile insurance coverages.

(f) Additional rating factors that the commissioner shall approve if the commissioner finds, on the basis of appropriate investigation and any public hearings the commissioner considers necessary, that the factors are consistent with the purposes of this chapter and that they would encourage innovation or encourage insureds to minimize the risks of loss from hazards insured against.

(3) Each insurer shall establish and maintain premium discount plans pursuant to the following:

(a) An automobile theft prevention and automobile recovery premium discount plan. A premium discount plan required under this subdivision shall provide for a premium discount for automobile comprehensive coverage based upon the installation of an approved automobile theft prevention or automobile recovery device. As used in this subdivision, "approved automobile theft prevention or automobile recovery device" means a device that is designed to prevent the theft of an insured's automobile or aid the police in the recovery of an insured's automobile and that is approved by the board of directors of the automobile theft prevention authority.

(b) An automobile safety belt premium discount plan. A premium discount plan required under this subdivision shall provide for a premium discount for automobile personal protection insurance in an amount that is actuarially sound. A premium discount plan established under this subdivision may require the insured individual to certify in writing that he or she will wear a safety belt while operating the insured motor vehicle in compliance with section 710e of the Michigan vehicle code, Act No. 300 of the Public Acts of 1949, being section 257.710e of the Michigan Compiled Laws, as a condition to receiving the premium discount. If an insured receives a premium discount after providing this certification and is injured while operating a motor vehicle without wearing a safety belt at the time of the injury, an insurer may impose a $500.00 deductible with respect to that loss in addition to any deductible provided in the policy and may subsequently deny to the insured the right to participate in any premium discount plan established by the insurer pursuant to this subdivision for a period of 12 months.

(4) Each insurer shall establish a secondary or merit rating plan for automobile insurance, other than comprehensive coverage. A secondary or merit rating plan required under this subsection shall provide for premium surcharges for any or all coverages for automobile insurance, other than comprehensive coverage, based upon any or all of the following when that information becomes available to the insurer:

(a) Substantially at-fault accidents.

(b) The suspension of the insured's license by the secretary of state under section 319(1)(c) to (f) of Act No. 300 of the Public Acts of 1949, being section 257.319 of the Michigan Compiled Laws, or a suspension under a substantially similar law of another state.

(c) Convictions for, determinations of responsibility for civil infractions for, or findings of responsibility in probate court for civil infractions for any of the following:

(*i*) Violations under chapter VI of the Michigan vehicle code, Act No. 300 of the Public Acts of 1949, as amended, being sections 257.601 to 257.750 of the Michigan Compiled Laws.

(*ii*) Operating a motor vehicle while license is suspended or revoked.

(*iii*) Operating a motor vehicle in violation of a license restriction under section 312 of Act No. 300 of the Public Acts of 1949, being section 257.312 of the Michigan Compiled Laws.

(*iv*) A violation substantially similar to any of the violations listed in subparagraphs (*i*) to (*iii*) under the laws of another state or local unit of government in this state or another state.

(5) Beginning 300 days after the effective date of the amendatory act that added this subsection and if uniformly offered and applied to all of the insurer's insureds, an insurer may elect not to surcharge an insured under subsection (4). A secondary or merit rating plan under subsection (4) shall provide for a flat dollar surcharge.

(6) An insurer shall not establish or maintain rates or rating classifications for automobile insurance based upon sex or marital status.

(7) Notwithstanding other provisions of this chapter, automobile insurance risks shall be grouped by territory, and territorial base rates for coverages shall be established as follows:

(a) Except as provided in subdivision (b), an insurer shall not be limited as to the number of territories employed in its rating plan and a territorial base rate may be made applicable in 1 or more territories contained in the rating plan of the insurer.

(b) Beginning 120 days after the effective date of the amendatory act that added this subdivision, each territory shall include at least 60,000 registered automobiles and shall consist of a single contiguous area. A territory that includes any portion of a city shall include the entire city except that any portion of a city that has 60,000 registered automobiles may be a separate territory if the remaining portion or portions of the city also have at least 60,000 registered automobiles. If a portion of a city that has 60,000 registered automobiles is made a separate territory, the dividing lines of that territory shall be comprised only of roadways that are state trunklines, county primary, or municipal major streets.

(8) This section shall not be construed as limiting insurers or rating organizations from establishing and maintaining statistical reporting territories. This section shall not be construed to prohibit an insurer from establishing or maintaining, for automobile insurance, a premium discount plan for senior citizens in this state who are 65 years of age or older, if the plan is uniformly applied by the insurer throughout this state. If an insurer has not established and maintained such a premium discount plan for senior citizens, the insurer shall offer reduced premium rates to senior citizens in this state who are 65 years of age or older and who drive less than 3,000 miles per year, regardless of statistical data.

(9) Classifications established pursuant to this section for home insurance other than inland marine insurance provided by policy floaters or endorsements shall be based only upon 1 or more of the following factors:

(a) Amount and types of coverage.

(b) Security and safety devices, including locks, smoke detectors, and similar, related devices.

(c) Repairable structural defects reasonably related to risk.

(d) Fire protection class.

(e) Construction of structure, based on structure size, building material components, and number of units.

(f) Loss experience of the insured, based upon prior claims attributable to factors under the control of the insured that have been paid by an insurer.

(g) Use of smoking materials within the structure.

(h) Distance of the structure from a fire hydrant.

(i) Availability of law enforcement or crime prevention services.

(10) Notwithstanding other provisions of this chapter, home insurance risks shall be grouped by territory, and territorial base rates for coverages shall be established as follows:

(a) An insurer shall not be limited as to the number of territories employed in its rating plan. However, an insurer shall not employ more than 3 different territorial base rates for a home insurance coverage. A territorial base rate may be made applicable in 1 or more territories contained in the rating plan of the insurer.

(b) An insurer shall not employ a territorial base rate for home insurance for owner-occupied dwelling policies that is less than 70% of the highest territorial base rate for the same policy, all other rating classifications being the same.

(c) An insurer shall not employ a territorial base rate for home insurance for renter or tenant policies that is less than 65% of the highest territorial base rate for the same policy, all other rating classifications being the same.

(11) An insurer may utilize factors in addition to those specified in this section for home insurance, if the commissioner finds, after a hearing held pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.328 of the Michigan Compiled Laws, that the factors would encourage innovation, would encourage insureds to minimize the risks of loss from hazards insured against, and would be consistent with the purposes of this chapter.

(12) If uniformly offered and applied to all the insurer's insureds, an automobile insurer may offer premium discounts based upon the length of time the insured has been free of substantially at-fault accidents with the insurer.

(13) If uniformly offered and applied to all the insurer's insureds, an automobile insurer may offer premium discounts based upon the length of time the insured has been insured with the insurer.

Sec. 2111b. A rate filing for automobile insurance package policies shall not be modified, changed, or altered for a period of 6 months after the effective date of the filing unless the modification, change, or alteration for the rating cells affected by the filing results in an overall premium reduction for the affected cells. Changes in risk symbols and changes in risk symbol applications and values shall only be made in conjunction with a rate filing. This section does not prohibit an insurer from making a rate filing at any time that only provides changes to rates based upon assessments levied against insurers pursuant to section 3104 or 3330. These rate filings shall not be considered a rate filing for purposes of this section.

Sec. 2111f. (1) By not later than 120 days after the effective date of the amendatory act that added this section, each insurer shall file base rates for automobile insurance that reflect the anticipated average premium savings resulting from the changes made in the amendatory act that added this section for personal protection insurance, residual liability insurance, uninsured motorist coverage, and collision and comprehensive coverages. In this filing, an automobile insurer's overall average rate for all coverages for insureds selecting the personal protection insurance coverage specified in section 3107(1)(a)(*i*) shall not be more than the overall average rate charged for all coverages by the automobile insurer on November 1, 1992 reduced by at least 16%. However, the personal protection insurance premium for an insured who selects the $5,000,000.00 personal protection insurance coverage specified in section 3107(1)(a)(*ii*) shall not be increased to an amount that is greater than what the insurer charged for personal protection insurance coverage on November 1, 1992. The rate reduction or premium for a specified insured may vary due to discounts, surcharges, application of chapter 21 rating factors, and coverage selection.

(2) By not sooner than 150 days after the effective date of the amendatory act that added this section and not later than 210 days after the effective date of the amendatory act that added this section, an insurer may petition the commissioner for relief from all or part of the percentage set in subsection (1). In its petition an insurer shall do both of the following:

(a) Demonstrate that based on its book of business the savings resulting from the changes made in the amendatory act that added this section do not justify all or part of the percentage set in subsection (1) and that the effect of the full rate reduction would produce a combined ratio for automobile insurance for the insurer in excess of the statewide average combined ratio for all automobile insurers for calendar years 1989 through 1992.

(b) Specify the percentage of rate reduction that is justified, based on its book of business, by the savings resulting from the changes made in the amendatory act that added this section and that is necessary to produce a combined ratio for the insurer equal to the statewide average combined ratio for all automobile insurers for calendar years 1989 through 1992.

(3) By not later than 60 days after receipt of a petition under subsection (2), the commissioner by order shall deny the insurer's request for regulatory relief or shall grant the insurer's request for regulatory relief in either the percentage specified in the insurer's petition or in such percentage that the commissioner determines appropriate.

(4) An insurer aggrieved by the commissioner's order under subsection (3) may request a hearing pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws. The costs associated with a hearing shall be paid for by the insurer.

(5) Nothing in this section prohibits an insurer from reducing rates by more than the percentage set in subsection (1).

Sec. 2111g. An insurer shall not charge an insured a premium for any assessment levied against the insurer pursuant to section 3330 or chapter 79 if the insurer uses the assessment as a credit under the single business tax act, Act No. 228 of the Public Acts of 1975, being sections 208.1 to 208.145 of the Michigan Compiled Laws.

Sec. 2111h. (1) The commissioner shall conduct a statewide loss ratio study for each automobile insurer and shall report to the senate and house of representatives standing committees on insurance issues on the results of the study 300 days after the effective date of the amendatory act that added this section and biennially thereafter.

(2) The commissioner shall examine and report to the senate and house of representatives standing committees on insurance issues 390 days after the effective date of the amendatory act that added this section on increases or decreases in automobile insurance rates by automobile insurers. After this initial report the commissioner shall examine and report to the senate and house of representatives standing committees on insurance issues 570 days after the effective date of the amendatory act that added this section and annually thereafter on increases or decreases in automobile insurance rates by automobile insurers.

(3) There is appropriated to the insurance bureau for the 1993-94 state fiscal year $50,000.00 for the purpose of preparing the reports required by this section.

Sec. 2112a. (1) An automobile insurer shall not increase the premium for an automobile insurance policy that is being renewed if the increase is due to an increase in rates unless the insurer sends the renewal notice showing the higher premium to the insured at least 30 days before the insurance policy renewal date. If an insurer does not send the renewal notice showing the higher premium to the insured at least 30 days before the insurance policy renewal date, the insured is not liable for the prorated portion of the increase in premium.

(2) As used in this section, "prorated portion of the increase in premium" means the amount of increase in premium divided by the number of days in the billing period multiplied by the number of days by which the insurer failed to send the 30-day notice required by this section.

Sec. 2115a. By not later than 120 days after the effective date of the amendatory act that added this section, automobile insurers shall establish and implement a market assistance plan that shall be subject to the commissioner's approval. The market assistance plan shall assist consumers in obtaining automobile insurance by establishing, maintaining, and advertising a statewide toll-free telephone number with sufficient capacity to provide adequate service through which consumers are able to obtain comparative automobile insurance rate information, the telephone numbers of automobile insurers, copies of the buyer's guide prepared pursuant to section 2115c, and information on consumers' rights to automobile insurance.

Sec. 2115b. (1) By October 1 of each year, each automobile insurer that has any agents located within Michigan and with a volume of business that places it in the top 85% of the private passenger nonfleet automobile insurance market in Michigan shall maintain at least 1 agent who is physically located and actively writing business in each rating territory in its rating plan.

(2) For purposes of this section:

(a) "Actively writing business" means having an office and regularly advertising for automobile insurance business.

(b) Volume of business shall be determined by net direct premium written in the previous calendar year.

Sec. 2115c. The commissioner shall prepare semiannually a buyer's guide to automobile insurance in Michigan in at least 8-point type. The buyer's guide shall compare rates among a reasonable representation of at least 50 automobile insurers in Michigan in each territory used by the principal advisory organization for statistical reporting purposes. Beginning April 1, 1996 the buyer's guide shall contain comparative complaint information. The commissioner shall have copies of the buyer's guide available to the general public and shall provide copies of the buyer's guide to the governor, to each member of the legislature, and to secretary of state branch offices for distribution to the public. The secretary of state shall mail with each notice of license plate renewal a notice that a buyer's guide to automobile insurance is available at each local secretary of state office and from the insurance bureau by writing or telephoning the insurance bureau.

Sec. 2115d. The commissioner shall prepare a report by October 1, 1993 and annually thereafter that provides damageability and repairability ratings for the most recent available model year of vehicles. These ratings shall be based on credible information provided by recognized automobile damage and repair experts from government and other institutions. The report shall include a description of the accuracy and usability of the developed ratings and a commentary on the best way to provide consumers with reliable information on the impact that vehicle resistance to damage and cost of repair, by various car makes and models, have on insurance rates. The report shall be made available to the public upon request, shall be given to the governor and members of the senate and house of representatives standing committees on insurance issues, and summations of the report shall be distributed to the media.

Sec. 2115e. An automobile insurer shall give to each insured who calls the insurer concerning a collision claim the telephone numbers for the following:

(a) The better business bureau.

(b) The bureau of automotive regulation.

(c) If applicable, the consumer affairs division of the nearest local unit of government.

Sec. 2118. (1) As a condition of maintaining its certificate of authority, an insurer shall not refuse to insure, refuse to continue to insure, or limit coverage available to an eligible person for automobile insurance, except in accordance with underwriting rules established pursuant to this section and sections 2119 and 2120.

(2) The underwriting rules that an insurer may establish for automobile insurance shall be based only on the following:

(a) Criteria identical to the standards set forth in section 2103(1).

(b) The insurance eligibility point accumulation in excess of the amounts established by section 2103(1) of a member of the household of the eligible person insured or to be insured, if the member of the household usually accounts for 10% or more of the use of a vehicle insured or to be insured. For purposes of this subdivision, a person who is the principal driver for 1 automobile insurance policy shall be rebuttably presumed not to usually account for more than 10% of the use of other vehicles of the household not insured under the policy of that person.

(c) With respect to a vehicle insured or to be insured, substantial modifications from the vehicle's original manufactured state for purposes of increasing the speed or acceleration capabilities of the vehicle.

(d) Type of vehicle insured or to be insured, based on 1 of the following, without regard to the age of the vehicle:

(*i*) The vehicle is of limited production or of custom manufacture.

(*ii*) The insurer does not have a rate lawfully in effect for the type of vehicle.

(*iii*) The vehicle represents exposure to extraordinary expense for repair or replacement under comprehensive or collision coverage.

(e) Use of a vehicle insured or to be insured for transportation of passengers for hire, for rental purposes, or for commercial purposes. Rules under this subdivision shall not be based on the use of a vehicle for volunteer or charitable purposes or for which reimbursement for normal operating expenses is received.

(f) Payment of a minimum deposit at the time of application or renewal, not to exceed the smallest deposit required under an extended payment or premium finance plan customarily used by the insurer.

(g) For purposes of requiring comprehensive deductibles of not more than $150.00, or of refusing to insure if the person refuses to accept a required deductible, the claim experience of the person with respect to comprehensive coverage.

(h) Total abstinence from the consumption of alcoholic beverages except if such beverages are consumed as part of a religious ceremony. However, an insurer shall not utilize an underwriting rule based on this subdivision unless the insurer has been authorized to transact automobile insurance in this state prior to January 1, 1981, and has consistently utilized such an underwriting rule as part of the insurer's automobile insurance underwriting since being authorized to transact automobile insurance in this state.

Sec. 2120. (1) Affiliated insurers may establish underwriting rules so that each affiliate will provide automobile insurance only to certain eligible persons. This subsection shall apply only if an eligible person can obtain automobile insurance from 1 of the affiliates. The underwriting rules shall be in compliance with this section and sections 2118 and 2119.

(2) An insurer may establish separate rating plans so that certain eligible persons are provided automobile insurance under 1 rating plan and other eligible persons are provided automobile insurance under another rating plan. This subsection shall apply only if all eligible persons can obtain automobile insurance under a rating plan of the insurer. Underwriting rules consistent with this section and sections 2118 and 2119 shall be established to define the rating plan applicable to each eligible person.

(3) Underwriting rules under this section shall be based only on the following:

(a) For a vehicle insured or to be insured, substantial modifications from the vehicle's original manufactured state for purposes of increasing the speed or acceleration capabilities of the vehicle.

(b) For purposes of insuring persons who have refused a deductible lawfully required under section 2118(2)(g), the claim experience of the person with respect to comprehensive coverage.

(c) Refusal of the person to pay a minimum deposit required under section 2118(2)(f).

(d) A person's insurance eligibility point accumulation under section 2103(1)(h), or the total insurance eligibility point accumulation of all persons who account for 10% or more of the use of 1 or more vehicles insured or to be insured under the policy.

(e) The type of vehicle insured or to be insured as provided in section 2118(2)(d).

Sec. 2134. Each insurer transacting automobile insurance in this state shall do both of the following:

(a) Be a paying member of the national insurance crime bureau.

(b) Secure from each insured the vehicle identification number for each vehicle insured by the insurer.

Sec. 2136. Each insurer, when writing automobile comprehensive insurance coverage for a person who was not previously a policyholder with the insurer or when insuring an automobile that was not previously insured by the insurer for a person who was previously a policyholder with the insurer but who has filed a claim with the insurer within the preceding 3 years to recover for the theft of an automobile, shall verify the existence of the automobile being insured. To comply with this section, an insurer shall either make a personal inspection of the automobile or obtain not less than 2 photographs of the automobile that depict the automobile diagonally from the front and rear. This section shall not apply when an agent subject to section 1209(2) transfers a person's automobile comprehensive insurance coverage from an insurer that has authorized the agent to another insurer that has authorized the agent.

Sec. 2138. An insurer shall not make a claim payment on an automobile insurance policy for a loss arising from the theft of an automobile covered under the policy unless the insured has filed a report of the theft to the state police or the law enforcement agency within whose jurisdiction the theft occurred.

Sec. 2140. (1) Subject to subsection (3), if the commissioner finds that a person or organization has violated a provision of this chapter or the rules promulgated pursuant to this chapter, the commissioner may order any or all of the following:

(a) Payment of a civil fine of not more than $5,000.00 for each violation, and if the violation is willful, a civil fine of not more than $25,000.00 for each violation. A fine collected under this subdivision shall be turned over to the state treasurer and credited to the general fund of the state.

(b) A cease and desist order.

(c) An order to comply.

(d) A refund of any overcharges with interest and penalties.

(2) The commissioner may suspend the authority of a rating organization or insurer to do business in this state who fails to comply with an order of the commissioner under this section within the time specified by the order, or any extension of the order that the commissioner may grant, but the suspension shall not affect the validity or continued effectiveness of rates previously filed and effective. The commissioner shall not suspend the authority of a rating organization or insurer to do business in this state for failure to comply with an order until the time prescribed for an appeal from the order has expired, or, if an appeal has been taken, until the order for the suspension has been affirmed. The commissioner may determine when a suspension of authority shall become effective, and the suspension shall remain in effect for the period fixed by the commissioner, unless the commissioner modifies or rescinds the suspension, or until the order upon which the suspension is based is modified, rescinded, or reversed.

(3) A civil fine shall not be imposed and the authority to do business in this state shall not be suspended or revoked except upon a written order of the commissioner, specifying the alleged violation and stating his or her findings, made after a hearing held upon not less than 10 days' written notice to the person or organization. An order issued by the commissioner pursuant to this section shall not require the payment of civil fines exceeding $50,000.00.

(4) The commissioner shall report annually to the senate and house of representatives standing committees on insurance issues on the amount of fines collected pursuant to this section.

Sec. 3015. (1) Each automobile insurance policy delivered or issued for delivery in this state that provides coverage for the theft of an automobile may include either or both of the following provisions:

(a) A provision that imposes a $500.00 deductible to the theft loss of the automobile if the automobile was unattended when stolen and was stolen while the keys to the automobile were located in the passenger compartment of the automobile. The deductible shall not apply if the automobile is the subject of a bailment contract.

(b) A provision that reduces the recovery under the policy by 10% for the theft loss of the automobile if the automobile was unattended when stolen and was stolen while the keys to the automobile were located in the passenger compartment of the automobile. The reduction under this subdivision shall not apply if the automobile is the subject of a bailment contract.

(2) If an insurer includes either or both of the provisions provided in subsection (1) in an automobile insurance policy that provides coverage for the theft of an automobile, the insurer shall include the provision or provisions in each

automobile insurance policy providing coverage for the theft of an automobile that is thereafter delivered or issued for delivery by the insurer.

Sec. 3037. (1) At the time a new applicant for the insurance required by section 3101 for a private passenger nonfleet automobile makes an initial written application to the insurer, an insurer shall offer both of the following collision coverages to the applicant:

(a) Limited collision coverage that pays for collision damage to the insured vehicle without a deductible amount if the operator of the vehicle is not substantially at fault in the accident from which the damage arose.

(b) Broad form collision coverage that pays for collision damage to the insured vehicle regardless of fault, with deductibles in such amounts as may be approved by the commissioner, which deductibles shall be waived if the operator of the vehicle is not substantially at fault in the accident from which the damage arose.

(2) Any payment of a claim under subsection (2) by an insurer shall be payable jointly to the policyholder and repair facility.

(3) In addition to the coverages offered pursuant to subsection (1), standard and limited collision coverage may be offered with deductibles as approved by the commissioner.

(4) If the applicant is required by the insurer to sign the written application form described in subsection (1), if the applicant chooses to reject both of the collision coverages, or limited collision without a deductible, offered under subsection (1), the rejection shall be made in writing either on a separate form or as part of the application, or some combination thereof, as approved by the commissioner. The rejection statement shall inform the applicant of his or her rights if damage occurs to the insured vehicle under the alternative coverage option selected.

(5) If a written application is made by mail and the applicant fails to sign or return a written rejection statement as required by subsection (4), the requirements of subsection (4) shall be considered to have been satisfied with respect to the insurer if all of the following occur:

(a) The application provides the applicant with an opportunity to select the coverages required to be offered under subsection (1).

(b) The applicant is requested to sign the rejection statement, either as part of the application or as a separate form issued with the application, if the applicant fails to select any of the coverages specified in subsection (1).

(c) The applicant signed the application as otherwise required by the insurer.

(6) At the time of the initial written application specified in subsection (1), an agent or insurer shall provide the applicant with a written explanation of collision coverage options in easily understandable language, if that information is not contained in the application form.

(7) At least annually in conjunction with the renewal of a private passenger nonfleet automobile insurance policy, or at the time of an addition, deletion, or substitution of a vehicle under an existing policy, other than a group policy, an insurer shall inform the policyholder, on a form approved by the commissioner, of all of the following:

(a) The current status of collision coverage, if any, for the vehicle or vehicles affected by the renewal or change and the rights of the insured if damage occurs to the insured vehicle under the current coverage.

(b) The collision coverages available under the policy and the rights of the insured if damage occurs to the insured vehicle under each collision option.

(c) Procedures for the policyholder to follow if he or she wishes to change the current collision coverage.

(8) As used in this section:

(a) "Collision damage" does not include losses customarily insured under comprehensive coverages.

(b) "Repair facility" means a motor vehicle repair facility as defined in section 1302 of the motor vehicle service and repair act, Act No. 300 of the Public Acts of 1974, being section 257.1302 of the Michigan Compiled Laws.

(c) "Substantially at fault" means a person's action or inaction was more than 50% of the cause of the accident.

(9) If damage occurs to an insured vehicle, an insured may use any repair facility for an estimate or the providing of repair services covered by the automobile insurance policy.

(10) An insurer may establish a direct repair program. If an insurer establishes a direct repair program, the insurer shall make available to all repair facilities the criteria necessary to participate in the direct repair program. Any repair facility that meets the established criteria is eligible to participate in the direct repair program. An insurer shall not prohibit an eligible repair facility from participating in the direct repair program, and an insurer shall not limit the number of repair facilities participating in a direct repair program.

Sec. 3101. (1) The owner or registrant of a motor vehicle required to be registered in this state shall maintain security for payment of benefits under personal protection insurance in an amount not less than that required in section 3107(1)(a)(*i*), property protection insurance, and residual liability insurance. Security shall only be required to be in effect during the period the motor vehicle is driven or moved upon a highway. Notwithstanding any other provision in

this act, an insurer that has issued an automobile insurance policy on a motor vehicle that is not driven or moved upon a highway may allow the insured owner or registrant of the motor vehicle to delete a portion of the coverages under the policy and maintain the comprehensive coverage portion of the policy in effect.

(2) As used in this chapter:

(a) "Automobile insurance" means that term as defined in section 2102.

(b) "Highway" means that term as defined in section 20 of the Michigan vehicle code, Act No. 300 of the Public Acts of 1949, being section 257.20 of the Michigan Compiled Laws.

(c) "Motorcycle" means a vehicle that is required to be registered for use on a public highway in this state having a saddle or seat for the use of the rider, designed for operation upon a public highway and to travel on not more than 3 wheels in contact with the ground, and that is equipped with a motor that exceeds 50 cubic centimeters piston displacement. The wheels on any attachment to the vehicle shall not be considered as wheels in contact with the ground. Motorcycle does not include a moped, as defined in section 32b of the Michigan vehicle code, Act No. 300 of the Public Acts of 1949, being section 257.32b of the Michigan Compiled Laws, or an ORV as defined in section 1 of Act No. 319 of the Public Acts of 1975, being section 257.1601 of the Michigan Compiled Laws.

(d) "Motorcycle accident" means a loss involving the ownership, operation, maintenance, or use of a motorcycle as a motorcycle, but not involving the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle.

(e) "Motor vehicle" means a vehicle that is required to be registered for use on a public highway in this state, including a trailer, and that is operated or designed for operation upon a public highway by power other than muscular power which has more than 2 wheels. Motor vehicle does not include a motorcycle or a moped, as defined in section 32b of Act No. 300 of the Public Acts of 1949, being section 257.32b of the Michigan Compiled Laws, or an ORV as defined in section 1 of Act No. 319 of the Public Acts of 1975, being section 257.1601 of the Michigan Compiled Laws. Motor vehicle does not include a farm tractor or other implement of husbandry that is not subject to the registration requirements of the Michigan vehicle code pursuant to section 216 of the Michigan vehicle code, Act No. 300 of the Public Acts of 1949, being section 257.216 of the Michigan Compiled Laws.

(f) "Motor vehicle accident" means a loss involving the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle regardless of whether the accident also involves the ownership, operation, maintenance, or use of a motorcycle as a motorcycle.

(g) "Owner" means any of the following:

(*i*) A person renting a motor vehicle or having the use of a motor vehicle, under a lease or otherwise, for a period that is greater than 30 days.

(*ii*) A person who holds the legal title to a vehicle, other than a person engaged in the business of leasing motor vehicles who is the lessor of a motor vehicle pursuant to a lease providing for the use of the motor vehicle by the lessee for a period that is greater than 30 days.

(*iii*) A person who has the immediate right of possession of a motor vehicle under an installment sale contract.

(h) "Ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle" means that the involvement of the motor vehicle in the injury was directly related to the transportation function of the motor vehicle.

(i) "Registrant" does not include a person engaged in the business of leasing motor vehicles who is the lessor of a motor vehicle pursuant to a lease providing for the use of the motor vehicle by the lessee for a period that is greater than 30 days.

(3) Security may be provided under a policy issued by an insurer duly authorized to transact business in this state that affords insurance for the payment of benefits described in subsection (1). A policy of insurance represented or sold as providing security shall be deemed to provide insurance for the payment of the benefits.

(4) Security required by subsection (1) may be provided by any other method approved by the secretary of state as affording security equivalent to that afforded by a policy of insurance, if proof of the security is filed and continuously maintained with the secretary of state throughout the period the motor vehicle is driven or moved upon a highway. The person filing the security has all the obligations and rights of an insurer under this chapter. When the context permits, "insurer" as used in this chapter, includes any person filing the security as provided in this section.

Sec. 3101a. (1) An insurer in conjunction with the issuance of an automobile insurance policy as defined in section 3303 shall provide 2 certificates of insurance to each policyholder. Each certificate of insurance shall list the market assistance plan's toll-free telephone number established pursuant to section 2115a. The insurer shall mark 1 of the certificates as the secretary of state's copy, and that copy or an electronically or electromagnetically transmitted facsimile of that copy shall be filed with the secretary of state by the policyholder upon application for a vehicle registration. The secretary of state shall not maintain the certificate of insurance received under this subsection on file.

(2) A person who supplies false information to the secretary of state under this section or who issues or uses an invalid certificate of insurance is guilty of a misdemeanor punishable by imprisonment for not more than 1 year, or a fine of not more than $1,000.00, or both.

Sec. 3103a. A person who is successful in a court action against an insurer for wrongfully denying benefits due under this chapter shall recover reasonable attorney fees from the insurer. This section applies to claims filed on and after 120 days after the effective date of the amendatory act that added this section.

Sec. 3104. (1) An unincorporated, nonprofit association to be known as the excess PIP association, hereinafter referred to as the association, is created. Each insurer engaged in writing insurance coverages that provide the security required by section 3101(1) within this state, as a condition of its authority to transact insurance in this state, shall be a member of the association and shall be bound by the plan of operation of the association. Each insurer engaged in writing insurance coverages that provide the security required by section 3103(1) within this state, as a condition of its authority to transact insurance in this state, shall be considered a member of the association, but only for purposes of assessments under subsection (7)(d). Except as expressly provided in this section, the association shall not be subject to any laws of this state with respect to insurers, but in all other respects the association shall be subject to the laws of this state to the extent that the association would be were it an insurer organized and subsisting under chapter 50.

(2) The association shall provide and each member shall accept indemnification for 100% of the amount of ultimate loss sustained under personal protection insurance coverages in excess of the following amounts in each loss occurrence:

(a) For an automobile policy issued or renewed before 300 days after the effective date of the amendatory act that added this subdivision, $250,000.00.

(b) For an automobile policy issued or renewed 300 days to and including 665 days after the effective date of the amendatory act that added this subdivision, $300,000.00.

(c) For an automobile policy issued or renewed 666 days to and including 1031 days after the effective date of the amendatory act that added this subdivision, $400,000.00.

(d) For an automobile policy issued or renewed on and after 1032 days after the effective date of the amendatory act that added this subdivision, $500,000.00, adjusted annually every October 1 by the lesser of 5% or the consumer price index, and rounded up to the nearest $25,000.00.

(3) An insurer may withdraw from the association only upon ceasing to write insurance that provides the security required by section 3101(1) in this state.

(4) An insurer whose membership in the association has been terminated by withdrawal shall continue to be bound by the plan of operation, and upon withdrawal, all unpaid premiums that have been charged to the withdrawing member shall be payable as of the effective date of the withdrawal.

(5) An unsatisfied net liability to the association of an insolvent member shall be assumed by and apportioned among the remaining members of the association as provided in the plan of operation. The association shall have all rights allowed by law on behalf of the remaining members against the estate or funds of the insolvent member for sums due the association.

(6) If a member has been merged or consolidated into another insurer or another insurer has reinsured a member's entire business that provides the security required by section 3101(1) in this state, the member and successors in interest of the member shall remain liable for the member's obligations.

(7) The association shall do all of the following on behalf of the members of the association:

(a) Assume 100% of all liability as provided in subsection (2).

(b) Establish procedures by which members shall promptly report to the association each claim that, on the basis of the injuries or damages sustained, may reasonably be anticipated to involve the association if the member is ultimately held legally liable for the injuries or damages. Solely for the purpose of reporting claims, the member shall in all instances consider itself legally liable for the injuries or damages. The member shall also advise the association of subsequent developments likely to materially affect the interest of the association in the claim.

(c) Maintain relevant loss and expense data relative to all liabilities of the association and require each member to furnish statistics, in connection with liabilities of the association, at the times and in the form and detail as may be required by the plan of operation.

(d) Subject to subsection (25), in a manner provided for in the plan of operation, calculate and charge to members of the association a total premium sufficient to cover the expected losses and expenses of the association that the association will likely incur during the period for which the premium is applicable. The premium shall include an amount to cover incurred but not reported losses for the period and may be adjusted for any excess or deficient premiums from previous periods. Excesses or deficiencies from previous periods may be fully adjusted in a single period or may be adjusted over several periods in a manner provided for in the plan of operation. Each member shall be charged an amount equal to that member's total earned car years of insurance providing the security required by section 3101(1) or 3103(1), or both, written in this state during the period to which the premium applies, multiplied by the average premium per car and adjusted to reflect the amount of coverage selected by each member's insureds under section 3107. The average premium per car shall be the total premium calculated divided by the total earned car years of insurance

providing the security required by section 3101(1) or 3103(1) written in this state of all members during the period to which the premium applies. As used in this subdivision, "car" includes a motorcycle.

(e) Require and accept the payment of premiums from members of the association as provided for in the plan of operation. The association shall do either of the following:

(*i*) Require payment of the premium in full within 45 days after the premium charge.

(*ii*) Require payment of the premiums to be made periodically to cover the actual cash obligations of the association.

(f) Receive and distribute all sums required by the operation of the association.

(g) Establish procedures for reviewing claims procedures and practices of members of the association. If the claims procedures or practices of a member are considered inadequate to properly service the liabilities of the association, the association may undertake or may contract with another person, including another member, to adjust or assist in the adjustment of claims for the member on claims that create a potential liability to the association and may charge the cost of the adjustment to the member.

(8) In addition to other powers granted to it by this section, the association may do all of the following:

(a) Sue and be sued in the name of the association. A judgment against the association shall not create any direct liability against the individual members of the association. The association may provide for the indemnification of its members, members of the board of directors of the association, and officers, employees, and other persons lawfully acting on behalf of the association.

(b) Reinsure all or any portion of its potential liability with reinsurers licensed to transact insurance in this state or approved by the commissioner.

(c) Provide for appropriate housing, equipment, and personnel as may be necessary to assure the efficient operation of the association.

(d) Pursuant to the plan of operation, adopt reasonable rules for the administration of the association, enforce those rules, and delegate authority, as the board considers necessary to assure the proper administration and operation of the association consistent with the plan of operation.

(e) Contract for goods and services, including independent claims management, actuarial, investment, and legal services, from others within or without this state to assure the efficient operation of the association.

(f) Hear and determine complaints of a company or other interested party concerning the operation of the association.

(g) Perform other acts not specifically enumerated in this section that are necessary or proper to accomplish the purposes of the association and that are not inconsistent with this section or the plan of operation.

(9) A board of directors is created, hereinafter referred to as the board, which shall be responsible for the operation of the association consistent with the plan of operation and this section.

(10) The plan of operation shall provide for all of the following:

(a) The establishment of necessary facilities.

(b) The management and operation of the association.

(c) Procedures to be utilized in charging premiums, including adjustments from excess or deficient premiums from prior periods.

(d) Procedures governing the actual payment of premiums to the association.

(e) Reimbursement of each member of the board by the association for actual and necessary expenses incurred on association business.

(f) The investment policy of the association.

(g) Any other matters required by or necessary to effectively implement this section.

(11) Each board shall include members that would contribute a total of not less than 40% of the total premium calculated pursuant to subsection (7)(d). Each director shall be entitled to 1 vote. The initial term of office of a director shall be 2 years.

(12) As part of the plan of operation, the board shall adopt rules providing for the composition and term of successor boards to the initial board, consistent with the membership composition requirements in subsections (11) and (13). Terms of the directors shall be staggered so that the terms of all the directors do not expire at the same time and so that a director does not serve a term of more than 4 years.

(13) The board shall consist of 5 directors and the commissioner shall be an ex officio member of the board without vote.

(14) Each director shall be appointed by the commissioner and shall serve until that member's successor is selected and qualified. The chairperson of the board shall be elected by the board. A vacancy on the board shall be filled by the commissioner consistent with the plan of operation.

(15) After the board is appointed, the board shall meet as often as the chairperson, the commissioner, or the plan of operation shall require, or at the request of any 3 members of the board. The chairperson shall retain the right to vote on all issues. Four members of the board shall constitute a quorum.

(16) An annual report of the operations of the association in a form and detail as may be determined by the board shall be furnished to each member.

(17) Not more than 60 days after the initial organizational meeting of the board, the board shall submit to the commissioner for approval a proposed plan of operation consistent with the objectives and provisions of this section, which shall provide for the economical, fair, and nondiscriminatory administration of the association and for the prompt and efficient provision of indemnity. If a plan is not submitted within this 60-day period, then the commissioner, after consultation with the board, shall formulate and place into effect a plan consistent with this section.

(18) The plan of operation, unless approved sooner in writing, shall be considered to meet the requirements of this section if it is not disapproved by written order of the commissioner within 30 days after the date of its submission. Before disapproval of all or any part of the proposed plan of operation, the commissioner shall notify the board in what respect the plan of operation fails to meet the requirements and objectives of this section. If the board fails to submit a revised plan of operation that meets the requirements and objectives of this section within the 30-day period, the commissioner shall enter an order accordingly and shall immediately formulate and place into effect a plan consistent with the requirements and objectives of this section.

(19) The proposed plan of operation or amendments to the plan of operation shall be subject to majority approval by the board, ratified by a majority of the membership having a vote, with voting rights being apportioned according to the premiums charged in subsection (7)(d) and shall be subject to approval by the commissioner.

(20) Upon approval by the commissioner and ratification by the members of the plan submitted, or upon the promulgation of a plan by the commissioner, each insurer authorized to write insurance providing the security required by section 3101(1) in this state, as provided in this section, shall be bound by and shall formally subscribe to and participate in the plan approved as a condition of maintaining its authority to transact insurance in this state.

(21) The association shall be subject to all the reporting, loss reserve, and investment requirements of the commissioner to the same extent as would a member of the association.

(22) Premiums charged members by the association shall be recognized in the rate-making procedures for insurance rates in the same manner that expenses and premium taxes are recognized.

(23) The commissioner or an authorized representative of the commissioner may visit the association at any time and examine any and all the association's affairs.

(24) The association shall not have liability for losses occurring before July 1, 1978.

(25) Notwithstanding any other provisions of this section, the association is authorized to assess members to recoup a deficiency that exists in the MCCA account established under subsection (27) only as provided in this subsection. The association shall evaluate annually the assets and liabilities of the association and determine if a deficiency exists. If a deficiency does exist, the association, in accordance with the plan of operation, shall assess members annually as follows:

(a) If the deficiency is less than $100,000,000.00, the full amount of the deficiency.

(b) If the deficiency is greater than or equal to $100,000,000.00, the greater of $100,000,000.00 or 12% of the deficiency.

(c) If an assessment under subdivision (a) or (b) is insufficient to permit the association to meet its payments, then the assessment shall be increased to an amount sufficient to meet those payments.

(26) Any change in the amounts listed in subsection (2) applies only to policies issued or renewed on and after the date of the change in the amount.

(27) The association shall maintain 2 separate accounts out of which members shall be indemnified for ultimate loss. An MCCA account shall indemnify for losses arising under policies issued or renewed effective before 120 days after the effective date of the amendatory act that added this subsection. An excess PIP account shall indemnify for losses arising out of policies issued or renewed on and after 120 days after the effective date of the amendatory act that added this subsection. Each account shall be self-supporting and there shall be no transfer of assets or liabilities between accounts.

(28) Beginning 120 days after the effective date of the amendatory act that added this subsection, an insurer shall be prohibited from separating the premium paid to either association from the personal protection premium stated on an automobile insurance declaration page.

(29) As used in this section:

(a) "Consumer price index" means the annual average percentage increase in the Detroit consumer price index for all items for the prior 12-month period as reported by the United States department of labor and as certified by the commissioner.

(b) "Ultimate loss" means the actual loss amounts that a member is obligated to pay and that are paid or payable by the member, and shall not include claim expenses. An ultimate loss is incurred by the association on the date that the loss occurs.

Sec. 3104a. (1) There is created a personal injury protection task force. The personal injury protection task force shall consist of members appointed by the commissioner.

(2) The personal injury protection task force shall prepare a plan to reduce the costs associated with automobile related injuries including catastrophic claims. The plan shall include but is not limited to the following:

(a) The study of the issue of structured settlements.

(b) The examination of the use of managed care, preferred provider arrangements, case management, treatment protocols, utilization review, rehabilitation, and other contractual arrangements. The examination of case management shall include the methods currently used by insurers and providers and may be extended to include an experimental case management process using criteria developed by the personal injury protection task force that would then be implemented by insurers, providers, and injured persons who volunteer to participate in the experimental case management process.

(c) The proposal of standards for assessing injuries and prognosis, making treatment goals, and implementing treatment.

(d) The investigation of cost shifting and other suspected abuses within the system including recommendations on limiting costs associated with rehabilitation and home and vehicle modification abuses.

(e) The examination of the mix of potential structures and options for delivery of products, services, and accommodations.

(f) The study of the use of qualified review and the use of independent medical examination.

(3) The personal injury protection task force shall report the plan to the governor and the senate and house of representatives standing committees on insurance issues by not later than 18 months after the effective date of this section.

Sec. 3104b. (1) An automobile insurer may use clinical care management for each insured whose personal protection insurance benefits are not expected to exceed the current indemnification amount listed in section 3104(2). An automobile insurer shall use clinical care management for each insured whose personal protection insurance benefits are expected to exceed the current indemnification amount listed in section 3104(2).

(2) An automobile insurer shall do the following:

(a) Develop clinical care management enrollment forms and procedures.

(b) Develop procedures for an injured person to select a clinical care manager and for the insurer to appoint a clinical care manager for those injured persons who do not select a clinical care manager.

(c) Neither appoint nor contract for clinical care management services with itself, an entity in which it has a financial interest, or another automobile insurer.

(d) Require an injured person to designate a clinical care manager prior to authorizing payment for services.

(e) Reimburse each clinical care manager reasonable fees for the development, management, and update of a clinical care management plan.

(3) A clinical care manager shall do the following:

(a) Submit an initial clinical care management plan with an insurer within 60 days of the insurer's request for a clinical care management plan.

(b) Develop a new clinical care management plan for an injured person expected to incur allowable expenses for a period which will exceed the duration of an initial or succeeding clinical care management plan.

(c) Maintain patient-physician confidentiality.

(4) As used in this section:

(a) "Clinical care management plan" means a written plan of a duration not greater than 6 months developed and documented by or under the direction of a clinical care manager setting forth the care and other products, services, and accommodations for an injured person's care, treatment, recovery, and rehabilitation. A clinical care management plan shall list and explain all services that are to be provided and a schedule for review at appropriate, periodic intervals determined by the clinical care manager. A revised clinical care management plan may be developed before 6 months have expired if an injured person's condition or needs change. An injured person, somebody authorized to speak and act on the injured person's behalf, or a health care provider may initiate a written request for a revised clinical care management plan. A request shall include the rationale for the revision.

(b) "Clinical care manager" means a licensed medical or osteopathic doctor, physiatrist, psychologist, nurse, social worker, or physical or occupational therapist who provides the type of care necessary for the injured person's care, treatment, recovery, or rehabilitation.

Sec. 3107. (1) Except as provided in subsection (3), personal protection insurance benefits are payable for the following:

(a) Allowable expenses that, for policies issued or renewed on or after 120 days after the effective date of the amendatory act that added subsection (7), are as provided in subparagraphs (*i*) and (*ii*), incurred for medically appropriate products, services, and accommodations for an injured person's care, recovery, or rehabilitation. For policies issued or renewed on or after 120 days after the effective date of the amendatory act that added subsection (7) and on forms approved by the commissioner, an insurer shall offer the following coverages and an insured shall select in writing 1 of the following coverages:

(*i*) Coverage for allowable expenses consisting of all reasonable charges incurred up to a maximum of $1,000,000.00 for medically appropriate products, services, and accommodations for an injured person's care, recovery, or rehabilitation. This limit shall be adjusted up annually by the commissioner beginning October 1, 1993 so that 99% of personal protection insurance benefit claims are fully covered by the limit provided for in this subparagraph. Any change in the limit applies only to benefits arising out of accidents occurring after the date of the change in the limit.

(*ii*) Coverage for allowable expenses consisting of all reasonable charges incurred up to $2,000,000.00, $3,000,000.00, $4,000,000.00, or $5,000,000.00 maximums as selected by the insured, and the insurer may offer additional coverage limits, for medically appropriate products, services, and accommodations for an injured person's care, recovery, or rehabilitation. Any change in the limits applies only to benefits arising out of accidents occurring after the date of the change in the limit.

(b) Work loss consisting of loss of income from work an injured person would have performed during the first 3 years after the date of the accident if he or she had not been injured. Work loss does not include any loss after the date on which the injured person dies. Because the benefits received from personal protection insurance for loss of income are not taxable income, the benefits payable for such loss of income shall be reduced 15% unless the claimant presents to the insurer in support of his or her claim reasonable proof of a lower value of the income tax advantage in his or her case, in which case the lower value shall apply. Beginning March 30, 1973, the benefits payable for work loss sustained in a single 30-day period and income earned by an injured person for work during the same period in an amount that together shall not exceed $1,000.00, which maximum applies pro rata to any lesser period of work loss. Beginning October 1, 1974, the maximum shall be adjusted annually every October 1 to reflect changes in the cost of living under rules prescribed by the commissioner but any change in the maximum applies only to benefits arising out of accidents occurring after the date of change in the maximum.

(c) Expenses not exceeding $20.00 per day reasonably incurred in obtaining ordinary and necessary services in lieu of those that, if he or she had not been injured, an injured person would have performed during the first 3 years after the date of the accident, not for income but for the benefit of himself or herself or of his or her dependent.

(2) The following apply to subsection (1):

(a) If an insured fails to select in writing on a form approved by the commissioner 1 of the coverages in subsection (1)(a), an insurer shall provide coverage in the amount set forth in subsection (1)(a)(*i*).

(b) Coverage limits under subsection (1)(a) are provided on a per individual per loss occurrence basis. Coverage under subsection (1)(a) applies only to benefits payable to the insured named in the policy, the insured's spouse, and any relative of either domiciled in the same household.

(c) A person who is not an insured named in a policy, the insured's spouse, or a relative of either domiciled in the same household is entitled only to coverage in the limit set forth in subsection (1)(a)(*i*).

(d) Personal protection insurance benefits are limited to the limit set forth in subsection (1)(a)(*i*) per individual per loss occurrence for accidents occurring in the state of Michigan if the injured person is a nonresident of Michigan and the injured person's benefits are payable under a policy delivered outside of Michigan only if eligible under section 3163.

(e) Personal protection insurance benefits are not payable to a nonresident injured in an accident occurring outside of Michigan to the extent the nonresident recovers medical or disability benefits under any other policy. If personal protection insurance benefits are payable to a nonresident under this subdivision, the benefits are limited to the limit set forth in subsection (1)(a)(*i*) per individual per loss occurrence.

(3) Each insurer transacting automobile insurance in this state shall offer a waiver to each person who is 60 years of age or older and in the event of an accidental bodily injury would not be eligible to receive work loss benefits under subsection (1)(b). An insurer shall offer a reduced premium rate to a person who waives coverage under this subsection for work loss benefits. Waiver of coverage for work loss benefits applies only to work loss benefits payable to the person or persons who have signed the waiver form.

(4) As used in this section:

(a) Medically appropriate products, services, and accommodations rendered or prescribed by a health care facility or health care provider are those that are medically necessary and do not include products, services, and accommodations that would have been needed or used by the injured person or a member of the injured person's household without regard to the loss occurrence. Under no circumstances shall an insurer be required to provide coverage for any product, service, or accommodation that is not medically appropriate and medically necessary for an injured person's care, recovery, or rehabilitation and reasonably likely to provide continued effectiveness with respect to the injured person's care, recovery, or rehabilitation. If an insured wants durable medical equipment that is more expensive than what the insurer has determined is actually medically appropriate and medically necessary, the cost of the equipment that the insurer has determined is medically appropriate and medically necessary shall be paid as partial payment for the durable medical equipment that the insured desires. If reimbursement for a product, service, or accommodation rendered or prescribed is initially rejected in whole or in part by an insurer as not being medically appropriate and medically necessary, the insurer, at the provider's request, shall have the decision reexamined by a provider who has the same license, certification, or registration as the provider who provided the product, service, or accommodation being reexamined or who has a license, registration, or certification with a scope of practice that includes the scope of practice of the license, registration, or certification of the provider who provided the product, service, or accommodation being reexamined. Each insurer shall designate a person with whom providers can discuss insurer determinations of what is medically appropriate and medically necessary. Disputes over reasonable charges and medically appropriate and medically necessary products, services, and accommodations shall be a question of law to be decided by the court.

(b) Expenses within personal protection insurance coverage shall not include charges for a hospital room in excess of a reasonable and customary charge for semiprivate accommodations except if the injured person requires special or intensive care, including but not limited to care provided by a psychiatric unit, or for funeral and burial expenses in excess of the amount set forth in the policy which shall not be less than $1,750.00 or more than $5,000.00.

(c) Expenses within personal protection insurance coverage shall not include experimental treatment or participation in research projects.

(d) Expenses for attendant care services provided by a home health agency are limited to the reasonable and customary charge of the agency for the appropriate skill level and time intensity of service. Expenses for attendant care services for home health care provided by licensed or unlicensed persons, including a member of the same household whether or not he or she is employed by a home health agency, are limited to the customary wage the individual would have received if in the employ of a home health agency commensurate with the person's qualifications. Expenses for attendant care services for supervision by members of the same household will not be covered in excess of 16 hours per day. Attendant care provided continuously for more than 6 months may be limited to quadriplegic spinal cord, brain injured, or similarly injured persons as diagnosed by the injured person's physician. As used in this subdivision, "attendant" means an individual who provides assistance to the injured person with activities of daily living including but not limited to ambulating, feeding, grooming, dressing, toileting, transfers, and supervision that may be required for safety of the injured person. An attendant may be a trained nurse or nursing assistant but an attendant providing attendant care shall not be reimbursed for practicing the profession of nursing.

(e) Expenses for skilled home care provided by a home health agency are limited to the reasonable and customary charge of the agency for the appropriate skill level and time intensity of service. Expenses for skilled home care provided by licensed or unlicensed persons, including a member of the same household whether or not he or she is employed by a home health agency, are limited to the customary wage the individual would have received if in the employ of a home health agency commensurate with the person's qualifications. Expenses for skilled home care by members of the same household will not be covered in excess of 16 hours per day.

(f) Expenses for medically appropriate psychological services that are reasonably likely to produce significant measurable improvement in the injured person's psychological status and that are prescribed by a physician or licensed psychologist shall be limited to a fixed-duration time period not to exceed 26 weeks and shall apply only if the need for the services arose out of the injured person's loss occurrence. The services may be extended for 1 additional time period not to exceed 26 weeks if the services are reasonably likely to produce significant measurable improvement in the injured person's psychological status. The 26 and 52 week period may be extended if it is reasonably likely that treatment of a longer duration, which may be intermittent over the years the case is managed, may produce significant measurable improvement in the injured person's psychological or neuropsychological status. Psychological services shall be provided by a person licensed under part 182 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.18201 to 333.18237 of the Michigan Compiled Laws, or by a social worker registered under article 16 of the occupational code, Act No. 299 of the Public Acts of 1980, being sections 339.1601 to 339.1610 of the Michigan Compiled Laws.

(g) Expenses for medically appropriate vocational rehabilitation services that are reasonably likely to produce significant rehabilitation shall be reimbursed for a fixed-duration time period not to exceed 52 weeks. The services may be extended for 1 additional time period not to exceed 52 weeks if the services are reasonably likely to produce significant rehabilitation and shall cease once the injured person has acquired employment skills.

(h) Expenses for home modification accommodations that are functionally necessary to meet the injured person's treatment, rehabilitation, maintenance, and daily living needs that are a result of his or her injuries shall not exceed $50,000.00 adjusted annually to reflect changes in the cost of living under rules prescribed by the commissioner but any change in the maximum applies only to benefits arising out of loss occurrences after the date of change in the maximum.

(i) Expenses for a special motor vehicle or motor vehicle modification accommodations that are functionally necessary for the vehicular mobility of the injured person are limited to necessary modifications to an existing motor vehicle, or if a special motor vehicle is required, the cost of the special vehicle and the functionally necessary modifications to it that are directly necessitated by and related to the injured person's injuries. Costs for replacement special motor vehicles or motor vehicle modifications shall not be incurred more frequently than once every 7 years and are limited to a maximum of $50,000.00 every 7 years adjusted annually to reflect changes in the cost of living under rules prescribed by the commissioner.

(5) An insurer shall directly reimburse a provider of services received pursuant to this chapter unless the insured has already directly reimbursed the provider of services.

(6) Regardless of the number of motor vehicles insured or insurers providing security in accordance with this chapter, or the provisions of any other law providing for direct benefits without regard to fault for motor or any other vehicle accidents, a person shall not recover duplicate benefits for the same expenses or losses incurred under this section.

(7) A health care facility or health care provider shall not bill an insured or report to a credit reporting agency an insured's failure to pay for products, services, and accommodations rendered when an amount is disputed by the insurer or when that amount exceeds the payment made by the insurer. If an insured receives medical care from a health care facility or health care provider for an automobile accident injury, an assignment of the insured's rights to enforce coverage and collect medical care payments for services rendered and products provided by that health care facility or health care provider automatically passes to the health care facility or health care provider that rendered the services or provided the products.

(8) This section shall not be interpreted to exclude any health care provider providing services within the scope of their licensure, certification, or registration. As used in this subsection, "health care provider" means a person licensed, certified, or registered under parts 61 to 65 or 161 to 182 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.6101 to 333.6523 and 333.16101 to 333.18237 of the Michigan Compiled Laws.

Sec. 3109a. (1) An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. The deductibles and exclusions required to be offered by this section are subject to prior approval by the commissioner and apply only to benefits payable to the person named in the policy, the spouse of the insured, and any relative of either domiciled in the same household.

(2) Health and accident coverage that does not become effective until after the date of the injury is secondary to personal protection insurance benefits for all services related to the injury.

(3) Coverage under title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395c to 1395i, 1395i-2 to 1395i-4, 1395j to 1395t, 1395u to 1395w-2, 1395w-4 to 1395ccc, or title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396f and 1396i to 1396u, or coverage pursuant to a medicare supplemental policy or certificate or a contract issued by a health maintenance organization to an individual eligible for medicare is not considered other health and accident coverage for purposes of this section.

Sec. 3115. (1) Except as provided in section 3114(1), a person suffering accidental bodily injury while not an occupant of a motor vehicle shall claim personal protection insurance benefits from insurers in the following order of priority:

(a) Insurers of owners or registrants of motor vehicles involved in the accident.

(b) Insurers of operators of motor vehicles involved in the accident.

(2) When 2 or more insurers are in the same order of priority to provide personal protection insurance benefits an insurer paying benefits due is entitled to partial recoupment from the other insurers in the same order of priority, together with a reasonable amount of partial recoupment of the expense of processing the claim, in order to accomplish equitable distribution of the loss among such insurers.

(3) A limit upon the amount of personal protection insurance benefits available because of accidental bodily injury to 1 person arising from 1 motor vehicle accident shall be determined without regard to the number of policies applicable to the accident.

(4) Regardless of the number of vehicles insured under the policy, in no event shall the limit of liability for 2 or more motor vehicles or 2 or more policies be added together, combined, or stacked to determine the limit of insurance coverage available for each injured person covered under the policy.

Sec. 3116. (1) A subtraction from personal protection insurance benefits shall not be made because of the value of a claim in tort based on the same accidental bodily injury.

(2) A subtraction from or reimbursement for personal protection insurance benefits paid or payable under this chapter shall be made only if recovery is realized upon a tort claim arising from an accident occurring outside this state, a tort claim brought within this state against the owner or operator of a motor vehicle with respect to which the security required by section 3101 (3) and (4) was not in effect, or a tort claim brought within this state based on intentionally caused harm to persons or property, and shall be made only to the extent that the recovery realized by the claimant is for damages for which the claimant has received or would otherwise be entitled to receive personal protection insurance benefits. A subtraction shall be made only to the extent of the recovery, exclusive of reasonable attorneys' fees and other reasonable expenses incurred in effecting the recovery. If personal protection insurance benefits have already been received, the claimant shall repay to the insurers out of the recovery a sum equal to the benefits received, but not more than the recovery exclusive of reasonable attorneys' fees and other reasonable expenses incurred in effecting the recovery. The insurer shall have a lien on the recovery to this extent. A recovery by an injured person or his or her estate for loss suffered by the person shall not be subtracted in calculating benefits due a dependent after the death and a recovery by a dependent for loss suffered by the dependent after the death shall not be subtracted in calculating benefits due the injured person.

(3) A personal protection insurer with a right of reimbursement under subsection (1), if suffering loss from inability to collect reimbursement out of a payment received by a claimant upon a tort claim, is entitled to indemnity from a person who, with notice of the insurer's interest, made the payment to the claimant without making the claimant and the insurer joint payees as their interests may appear or without obtaining the insurer's consent to a different method of payment.

(4) A subtraction or reimbursement shall not be due the claimant's insurer from that portion of any recovery to the extent that recovery is realized for noneconomic loss as provided in section 3135(1) and (3)(b) or for allowable expenses, work loss, and survivor's loss as prescribed in sections 3107 to 3110 in excess of the amount recovered by the claimant from his or her insurer.

Sec. 3118. (1) A person who has reason to believe that an automobile insurer has improperly denied his or her claim for benefits shall appeal the denial pursuant to this section before filing an action for recovery of insurance benefits with the court.

(2) As a condition of its authority to transact automobile insurance in this state, an insurer shall establish reasonable internal procedures to provide claimants with a private informal managerial-level conference regarding a dispute over a claim for benefits. These procedures shall include all of the following:

(a) A notice to the claimant at the time of the denial of all or a part of the claim advising him or her of the right to appeal the denial within 90 days of the denial and the procedure to follow in requesting and obtaining a private informal managerial-level conference with the insurer.

(b) A method of providing the claimant, upon request and payment of a reasonable copying charge, with information pertinent to the denial.

(c) A designation of 1 or more managerial-level persons who have the authority to resolve claim denials on behalf of the insurer, who shall represent the insurer at the conference.

(d) A method for resolving the dispute promptly and informally, while protecting the interests of both the claimant and the insurer.

(3) The insurer shall file with the commissioner a list of the person or persons that it has designated to conduct the informal managerial-level conferences required by this section.

(4) The insurer shall provide a conference within 30 days after a request by a claimant, shall inform the claimant in writing of the insurer's decision within 30 days after the conference, and shall advise the claimant in writing that if the claimant is not satisfied with the insurer's decision, the claimant must request a conciliation conference with the commissioner within 30 days after notice of the insurer's decision and must proceed with a conciliation conference with the commissioner before the claimant may file an action for recovery of insurance benefits with the court.

(5) The commissioner shall provide a conciliation conference within 30 days after a request by a claimant and shall inform the claimant in writing of the commissioner's decision within 30 days after the conciliation conference. The commissioner's recommendation following a conciliation conference is admissible in any subsequent court action.

(6) The commissioner shall promulgate rules pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws, to establish a procedure for providing a conciliation conference under this section that shall be reasonably designed to resolve matters informally and as rapidly as possible, while protecting the interests of both the claimant and the insurer. The commissioner shall submit these rules to a public hearing pursuant to Act No. 306 of the Public Acts of 1969 by not later than 180 days after the effective date of the amendatory act that added this section.

(7) There shall be no requirement for a claimant to have an attorney present at any conference under this section.

(8) This section shall take effect 120 days after the effective date of the amendatory act that added this section.

Sec. 3135. (1) A person remains subject to tort liability for noneconomic loss caused by his or her ownership, maintenance, or use of a motor vehicle only if the injured person has suffered death, serious impairment of body function, or permanent serious disfigurement.

(2) For a cause of action for damages pursuant to subsection (1) filed on or after 120 days after the effective date of the amendatory act that added this subsection, all of the following apply:

(a) The injured person shall not have suffered serious impairment of body function unless the person has suffered an objectively manifested impairment of an important body function that affects his or her general ability to lead his or her normal life. The issue of whether an injured person has suffered serious impairment of body function shall be a question of law for the court.

(b) Damages shall be assessed on the basis of comparative fault, except that damages shall not be assessed in favor of a party who is more than 50% at fault.

(c) Damages shall not be assessed in favor of a party who was operating his or her own vehicle at the time the damage occurred and did not have in effect for the same motor vehicle involved in the accident the security required by section 3101 at the time the damage occurred.

(3) Notwithstanding any other provision of law, tort liability arising from the ownership, maintenance, or use within this state of a motor vehicle with respect to which the security required by section 3101 was in effect is abolished except as to:

(a) Intentionally caused harm to persons or property. Even though a person knows that harm to persons or property is substantially certain to be caused by his or her act or omission, the person does not cause or suffer such harm intentionally if he or she acts or refrains from acting for the purpose of averting injury to any person, including himself or herself, or for the purpose of averting damage to tangible property.

(b) Damages for noneconomic loss as provided and limited in subsections (1) and (2).

(c) Damages for allowable expenses, work loss, and survivor's loss as defined in sections 3107 to 3110 in excess of the daily, monthly, and 3-year limitations contained in those sections. The party liable for damages is entitled to an exemption reducing his or her liability by the amount of taxes that would have been payable on account of income the injured person would have received if he or she had not been injured.

(d) Damages up to $500.00 to motor vehicles, to the extent that the damages are not covered by insurance. An action for damages pursuant to this subdivision shall be conducted in compliance with subsection (4).

(4) In an action for damages pursuant to subsection (3)(d):

(a) Damages shall be assessed on the basis of comparative fault, except that damages shall not be assessed in favor of a party who is more than 50% at fault.

(b) Liability shall not be a component of residual liability, as prescribed in section 3131, for which maintenance of security is required by this act.

(5) Actions under subsection (3)(d) shall be commenced, whenever legally possible, in the small claims division of the district court or the municipal court. If the defendant or plaintiff removes the action to a higher court and does not prevail, the judge may assess costs.

(6) A decision of a court made pursuant to subsection (3)(d) shall not be res judicata in any proceeding to determine any other liability arising from the same circumstances as gave rise to the action brought pursuant to subsection (3)(d).

(7) In an action for damages pursuant to subsection (1) or (3)(a) filed on or after 120 days after the effective date of the amendatory act that added this subsection:

(a) The court presiding over the action shall, after a jury verdict, do 1 of the following within 21 days after entry of the judgment:

(*i*) Concur in the award.

(*ii*) On its own motion or on the motion of any party, review the excessiveness or inadequacy of the amount awarded and determine the appropriate amount.

(b) In determining the excessiveness or inadequacy of the amount awarded under subdivision (a)(*ii*), the court shall consider all of the following factors:

(*i*) The evidence presented at trial.

(*ii*) Whether the amount awarded was within the limits of what reasonable minds would consider just compensation for the injury and damages sustained.

(*iii*) Whether the amount awarded is comparable to awards in similar cases within the state and in other jurisdictions.

(*iv*) Whether the amount awarded was the result of improper methods, prejudice, passion, partiality, sympathy, corruption, or mistake of law or fact.

(c) If the court finds that the only error in the trial is the inadequacy or excessiveness of the amount awarded, the court may grant a new trial on the issue of the amount of damages only unless, within 14 days, the parties consent in writing to the entry of a judgment in an amount determined by the court.

Sec. 3142. (1) Personal protection insurance benefits are payable as loss accrues.

(2) Personal protection insurance benefits are overdue if not paid within 30 days after an insurer receives reasonable proof of the fact and of the amount of loss sustained. If reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within 30 days after the proof is received by the insurer. Any part of the remainder of the claim that is later supported by reasonable proof is overdue if not paid within 30 days after the proof is received by the insurer. For the purpose of calculating the extent to which benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery.

(3) An overdue payment bears interest at the rate set by section 6013(6) of the revised judicature act of 1961, Act No. 236 of the Public Acts of 1961, being section 600.6013 of the Michigan Compiled Laws. Interest paid under this subsection shall be offset by interest payable under section 6013(6) of Act No. 236 of the Public Acts of 1961.

Sec. 3145. (1) Beginning 120 days after the effective date of the amendatory act that added this subsection, an action for recovery of insurance benefits payable under this chapter shall not be commenced unless the claimant has appealed the denial of benefits through the informal dispute resolution process described in section 3118. Any statute of limitations period applicable to the recovery of insurance benefits payable under this chapter excluding the period listed in subsection (2) is tolled until the claimant has appealed the denial of benefits through the informal dispute resolution process described in section 3118.

(2) An action for recovery of personal protection insurance benefits payable under this chapter for accidental bodily injury shall not be commenced later than 1 year after the date of the accident causing the injury unless written notice of injury as provided herein has been given to the insurer within 1 year after the accident causing the injury or unless the insurer has previously made a payment of personal protection insurance benefits for the injury.

(3) If the notice has been given or a payment has been made under subsection (2), the action may be commenced at any time within 1 year after the most recent allowable expense, work loss, or survivor's loss has been incurred. However, the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced.

(4) The notice of injury required by subsection (2) may be given to the insurer or any of its authorized agents by a person claiming to be entitled to benefits therefor, or by someone in his or her behalf. The notice shall give the name and address of the claimant and indicate in ordinary language the name of the person injured and the time, place, and nature of his or her injury.

(5) An action for recovery of property protection insurance benefits shall not be commenced later than 1 year after the accident.

Sec. 3157. (1) Subject to subsections (2) and (3), a physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services, and accommodations rendered. The charge to an injured person or his or her personal protection insurer shall not exceed the amount the person or institution customarily charges and accepts as payment in full for like products, services, and accommodations in cases not involving personal protection insurance.

(2) By not later than 90 days after the effective date of the amendatory act that added this subsection and continuing until a schedule of fees is implemented pursuant to subsection (3), a physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury are limited to, and shall be paid by the automobile insurer at, either of the following as selected by the provider:

(a) The amount paid for treatment, service, accommodation, and medicine pursuant to payment under, or schedules of maximum fees for worker's compensation contained in, R 418.101 to R 418.2324 of the Michigan administrative code.

(b) For a health care facility, 113% of the ratio of a participating health care facility's costs to its charges for the prior calendar year as used in the development of reimbursement to that provider by a payer authorized under the nonprofit health care corporation reform act, Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws, multiplied by the prior calendar year's charges for specific automobile accident injury treatments, services, accommodations, and medicines. For a health care provider, 110% of the amount paid for treatment, service, accommodation, and medicine pursuant to schedules of maximum fees issued by a payer authorized

under Act No. 350 of the Public Acts of 1980. For facilities in a provider class plan where controlled charges are paid by a nonprofit health care corporation, controlled charges shall also be paid by automobile insurers. This subdivision shall not be interpreted as requiring a nonprofit health care corporation to reveal any participating provider plans. Any information needed for reimbursement under this subdivision shall come from health care facilities and health care providers who elect to be paid pursuant to this subdivision.

(3) The commissioner shall establish schedules of fees pursuant to rules promulgated by the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws, that a physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance and a person or institution providing rehabilitative occupational training following the injury shall be limited to for reimbursement. The rules shall be submitted for a public hearing by 21 months after the effective date of the amendatory act that added this subsection. The commissioner shall provide for an advisory committee to aid and assist the commissioner in establishing the schedules of maximum fees under this subsection for any charges or fees that are payable under this subsection. The advisory committee shall be appointed by and serve at the pleasure of the commissioner.

(4) Unless an automobile insurer can demonstrate to the commissioner's satisfaction that a utilization review system will not be cost effective, each insurer shall implement a utilization review system. A utilization review system shall be automated and include all of the following:

(a) A provider enrollment file.

(b) Uniform claims forms.

(c) Uniform diagnosis and procedure code systems.

(d) Uniform place of service codes that indicate the setting where the service was rendered.

(e) Uniform codes to identify other liable third party payers.

(f) Type of service codes.

(g) Quantification of the dollar amounts of all claims rejected to and paid by other liable parties.

(h) A mechanism for identifying and rejecting claims that fail to meet the requirements of the statute of limitations.

(i) A mechanism for identifying and rejecting nonaccident related claims for review.

(5) Each automobile insurer shall report annually to the commissioner in a form designated by the commissioner the results of its utilization review system established under subsection (4). The report shall include at a minimum the following information:

(a) The savings derived through coordination of benefits with health care coverage carriers.

(b) The savings derived from identification of duplicate claims.

(c) The savings derived from identification of rejection of nonaccident related claims.

(d) All procedures identified as having been performed at facilities not licensed for those procedures including the names of the facilities involved.

(e) Number of claims and amounts expended, by type of medical and rehabilitative and therapeutic services, for claims processed and paid for the year.

(6) Automobile insurers shall not use a utilization review system in bad faith or to do either of the following:

(a) Unduly delay payment of legitimate claims.

(b) Harass or discriminate against medical providers or injured automobile accident victims.

(7) A health care facility and health care provider shall accept the amount reimbursed under subsections (2) and (3) as payment in full.

(8) Nothing in this section requires a health care facility or health care provider to accept a payment at a rate less than what is provided for in subsections (2) and (3) and an insurer is not required to pay more than the health care facility's or health care provider's usual and customary charge.

(9) This act does not preclude health care facilities or health care providers from contracting with insurers for reimbursement levels that vary from those in this section.

Sec. 3172. (1) A person entitled to a claim because of accidental bodily injury arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle in this state may obtain personal protection insurance benefits through an assigned claims plan in any of the following situations:

(a) If no personal protection insurance is applicable to the injury.

(b) If no personal protection insurance applicable to the injury can be identified.

(c) If the personal protection insurance applicable to the injury cannot be ascertained because of a dispute between 2 or more automobile insurers concerning their obligation to provide coverage or the equitable distribution of the loss.

(d) If the only identifiable personal protection insurance applicable to the injury is, because of financial inability of 1 or more insurers to fulfill their obligations, inadequate to provide benefits up to the maximum prescribed.

(2) In any of the situations under subsection (1), unpaid benefits due or coming due are subject to being collected under the assigned claims plan, and the insurer to which the claim is assigned, or the assigned claims facility if the claim is assigned to it, is entitled to reimbursement from the defaulting insurers to the extent of their financial responsibility.

(3) Except as otherwise provided in this subsection, personal protection insurance benefits, including benefits arising from accidents occurring before the effective date of this subsection, payable through an assigned claims plan shall be reduced to the extent that benefits covering the same loss are available from other sources, regardless of the nature or number of benefit sources available and regardless of the nature or form of the benefits, to a person claiming personal protection insurance benefits through the assigned claims plan. This subsection only applies when the personal protection insurance benefits are payable through the assigned claims plan because no personal protection insurance is applicable to the injury, no personal protection insurance applicable to the injury can be identified, or the only identifiable personal protection insurance applicable to the injury is, because of financial inability of 1 or more insurers to fulfill their obligations, inadequate to provide benefits up to the maximum prescribed. As used in this subsection "sources" and "benefit sources" do not include the program for medical assistance for the medically indigent under the social welfare act, Act No. 280 of the Public Acts of 1939, being sections 400.1 to 400.119b of the Michigan Compiled Laws, or insurance under the health insurance for the aged act, title XVIII of the social security amendments of 1965.

(4) If the obligation to provide personal protection insurance benefits cannot be ascertained because of a dispute between 2 or more automobile insurers concerning their obligation to provide coverage or the equitable distribution of the loss, and if a method of voluntary payment of benefits cannot be agreed upon among or between the disputing insurers, all of the following shall apply:

(a) The insurers who are parties to the dispute shall, or the claimant may, immediately notify the assigned claims facility of their inability to determine their statutory obligations.

(b) The claim shall be assigned by the assigned claims facility to an insurer which shall immediately provide personal protection insurance benefits to the claimant or claimants entitled to benefits in the highest amount applicable among the policies in dispute.

(c) An action shall be immediately commenced on behalf of the assigned claims facility by the insurer to whom the claim is assigned in circuit court for the purpose of declaring the rights and duties of any interested party.

(d) The insurer to whom the claim is assigned shall join as parties defendant each insurer disputing either the obligation to provide personal protection insurance benefits or the equitable distribution of the loss among the insurers.

(e) The circuit court shall declare the rights and duties of any interested party whether or not other relief is sought or could be granted.

(f) After hearing the action, the circuit court shall determine the insurer or insurers, if any, obligated to provide the applicable personal protection insurance benefits and the equitable distribution, if any, among the insurers obligated therefor, and shall order reimbursement to the assigned claims facility from the insurer or insurers to the extent of the responsibility as determined by the court. The reimbursement ordered under this subdivision shall include all benefits and costs paid or incurred by the assigned claims facility and all benefits and costs paid or incurred by insurers determined not to be obligated to provide applicable personal protection insurance benefits, including reasonable attorney fees and interest at the rate prescribed in section 3175 as of December 31 of the year preceding the determination of the circuit court.

(5) If no personal protection insurance is applicable to the injury or no personal protection insurance applicable to the injury can be identified, personal protection insurance benefits shall be paid only to the limit provided for in section 3107(1)(a)(*i*). If the only identifiable personal protection insurance applicable to the injury is, because of financial inability of 1 or more insurers to fulfill their obligations, inadequate to provide benefits up to the maximum prescribed, personal protection insurance benefits shall be paid to the limit selected by the insured under section 3107(1)(a).

(6) This section does not apply and section 3172a does apply if applicable personal protection insurance benefits are unavailable because an insurer otherwise obliged to provide that coverage under this chapter became, after October 1, 1993, an insolvent insurer as defined in chapter 79.

Sec. 3172a. (1) A person entitled to a claim because of accidental bodily injury arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle in this state may obtain the full personal protection insurance benefits entitled through the Michigan property and casualty guaranty association established under chapter 79 if all of the following are satisfied:

(a) Personal protection insurance applicable to the injury is unavailable because an insurer otherwise obliged to provide that coverage under this chapter became, after October 1, 1993, an insolvent insurer as defined in chapter 79.

(b) Except as provided in subsection (2), the claim satisfies the requirements of a covered claim under chapter 79.

(2) Notwithstanding section 7931(3), the obligation of the Michigan property and casualty guaranty association under this section shall be in the same priority as that of the insolvent insurer, but for its insolvency, under sections 3114 and 3115.

CHAPTER 32A

AUTOMOBILE INSURANCE ANTIFRAUD PLANS AND PROVISIONS

Sec. 3275. As used in this chapter:

(a) "Antifraud plan" means an automobile antifraud plan established under section 3277.

(b) "Office" means the automobile insurance fraud office established under section 3285.

Sec. 3277. (1) Each insurer authorized to transact automobile insurance in this state shall establish and maintain an automobile insurance antifraud plan and may establish and maintain an automobile insurance antifraud plan in conjunction with other automobile insurers. By not later than 300 days after the effective date of the amendatory act that added this chapter, the antifraud plan of insurers authorized to transact automobile insurance in this state on the effective date of the amendatory act that added this chapter shall be filed with the commissioner. An admitted automobile insurer that begins writing automobile insurance after the effective date of the amendatory act that added this chapter shall file an antifraud plan with the commissioner before initiating the writing of automobile insurance. An automobile insurer authorized to transact automobile insurance in this state after the effective date of this section shall file an antifraud plan within 6 months after authorization. A modification to the antifraud plan shall be filed with the commissioner within 30 days after the plan has been modified.

(2) Each antifraud plan established under subsection (1) shall contain all of the following:

(a) Specific procedures to prevent insurance fraud, including internal fraud involving employees or company representatives, fraud resulting from misrepresentation on applications for insurance coverage, and claims fraud.

(b) Specific procedures to review claims in order to detect evidence of possible insurance fraud and to investigate claims where fraud is suspected.

(c) A requirement to report suspected fraud to the appropriate law enforcement agencies, and to cooperate with those agencies in their investigation and prosecution of fraud cases.

(d) A requirement to undertake civil actions, if appropriate, against persons who have been convicted of fraudulent activities.

(e) A requirement to report annually to the office the number of cases of suspected fraud reported or filed under subdivisions (c) and (d).

(3) Each antifraud plan shall be filed with the commissioner. If, after review, the commissioner finds that the antifraud plan does not comply with subsection (2), the antifraud plan shall be disapproved. Notice of disapproval shall include a statement of the specific reasons for the disapproval. An antifraud plan disapproved by the commissioner shall be amended and refiled within 60 days after the date of the disapproval notice.

(4) The commissioner may audit an insurer to ensure compliance with the insurer's antifraud plan as a part of an examination performed under this act.

Sec. 3279. (1) Each insurer authorized to transact automobile insurance in this state shall provide annually to the commissioner a summary report on actions taken under the insurer's antifraud plan to prevent and combat insurance fraud, including, but not limited to, measures taken to protect and ensure the integrity of electronic data processing - generated data and manually compiled data, statistical data on the amount of resources committed to combating fraud, and the amount of fraud identified and recovered during the reporting period.

(2) An antifraud plan or summary report filed with the commissioner under this section and section 3277 and any reports or materials related to such a plan or report are not subject to the freedom of information act, Act No. 442 of the Public Acts of 1976, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

Sec. 3281. (1) Each insurer authorized to transact automobile insurance in this state and its employees, agents, and independent adjusters is required to report the incidence of suspected insurance fraud to the appropriate federal, state, or local criminal law enforcement authority. Licensed insurance agents and independent adjusters may elect to report suspected fraud through the affected insurer with which they have a contractual relationship. All reports of insurance fraud to law enforcement authorities shall be made in writing, and copies of the report shall be sent within 7 days to the office. If suspected insurance fraud involves agents or independent adjusters, a copy of the report shall also be sent to the commissioner.

(2) A person required to report suspected fraud under this chapter is not subject to any liability arising out of the filing of any reports or the furnishing of any information required by this chapter.

Sec. 3283. An insurer that fails to file in a timely manner an antifraud plan as required by section 3277 or an insurer that does not make a good faith attempt to file an antifraud plan that complies with section 3277 is subject to a civil penalty for each violation not to exceed $5,000.00 at the commissioner's discretion after consideration of all relevant factors, including the willfulness of the violation. An insurer that fails to follow its approved antifraud plan is subject to a civil penalty for each violation, not to exceed $10,000.00, at the commissioner's discretion after consideration of all relevant factors, including the willfulness of the violation.

Sec. 3285. The commissioner after consultation with insurers authorized to transact automobile insurance in this state shall establish, within the insurance bureau, a motor vehicle insurance fraud office. Within 180 days of its establishment, the commissioner shall establish a plan of operation for the office that is consistent with the provisions of this chapter. The plan of operation shall include, but not be limited to, all of the following:

(a) Detailed procedures for all insurers to regularly report fraud-related data to the office.

(b) Policies and procedures governing insurer and law enforcement agency access to office data, information, and reports.

(c) A detailed accounting of how information on insurance fraud filed by insurers will be organized and maintained.

(d) Any other information, data, procedure, or program relating to insurance fraud as may be required by the commissioner or determined necessary to facilitate the reporting and use of information and data.

Sec. 3287. (1) Except as provided in subsections (3) and (4), each insurer authorized to transact automobile insurance in this state, as a condition of its authority to transact the business of insurance in this state, shall report information on suspected fraudulent claims and applications for benefits arising out of the maintenance and use of a motor vehicle in this state with the office within 45 days of receipt of the application or claim.

(2) The information filed by an insurer under subsection (1) shall include, but is not limited to, all of the following:

(a) Identification of claimants.

(b) Identification of medical providers.

(c) Identification of repair shops.

(d) Identification of insurance adjusters.

(e) Identification of attorneys representing claimants.

(f) Description of claims.

(g) Other information considered relevant by the submitting insurer or the office.

(h) Other information required by the commissioner.

(3) The commissioner shall promulgate rules pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws, permitting a person to contest the accuracy of any reported information.

Sec. 3289. Each insurer authorized to transact automobile insurance in this state shall report to the office all relevant information on suspected fraudulent applications or claims as provided for in section 3287.

Sec. 3291. The commissioner shall issue an annual report listing all insurance companies that are complying with this chapter. Information about suspected fraud that is reported to the office shall be made available, as appropriate, to law enforcement officials and any insurer authorized to transact automobile insurance in this state.

Sec. 3295. On or before October 1 of each year the office, on behalf of the commissioner, shall file an annual report on the nature and effect of automobile insurance fraud in this state. The report shall present statistical data on fraud in this state. The commissioner may prescribe by regulation the content of the report.

Sec. 3297. All applications for insurance, renewals, and claim forms shall contain a statement that clearly states in substance the following:

> Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to 1 year for a misdemeanor conviction or up to 10 years for a felony conviction and payment of a fine of up to $5,000.00.

Sec. 3320. (1) Effective 300 days after the effective date of the amendatory act that added this subsection, the facility shall establish rates that are designed to be self-supporting for eligible private passenger nonfleet automobile insureds, ineligible private passenger nonfleet automobile insureds, and all other automobile insurance.

(2) The facility, with respect to private passenger nonfleet automobiles, shall provide for all of the following:

(a) The equitable distribution of applicants to designated participating members in accordance with the plan of operation.

(b) Issuance of policies of automobile insurance to qualified applicants as provided in the plan of operation.

(c) The appointment of a number of participating members appointed by the facility to act on behalf of the facility for the distribution of risks or for the servicing of insureds, as provided in the plan of operation and consistent with this section. The facility shall do all of the following:

(*i*) Appoint those members having the 5 highest participation ratios, as defined in section 3303(e)(*i*) to act on behalf of the facility.

(*ii*) Appoint other members to act on behalf of the facility who volunteer to so act and who meet reasonable servicing standards established in the plan of operation, up to a maximum of 5 in addition to those appointed pursuant to subparagraph (*i*).

(*iii*) Appoint additional members to act on behalf of the facility as necessary to do all of the following:

(A) Assure convenient access to the facility for all citizens of this state.

(B) Assure a reasonable quality of service for persons insured through the facility.

(C) Assure a reasonable representation of the various insurance marketing systems.

(D) Assure reasonable claims handling.

(E) Assure a reasonable range of choice of insurers for persons insured through the facility.

(d) Standards and monitoring procedures to assure that participating members acting on behalf of the facility do all of the following:

(*i*) Provide service to persons insured through the facility equivalent to the service provided to persons insured by the insurer voluntarily.

(*ii*) Handle claims in an efficient and reasonable manner.

(*iii*) Provide internal review procedures for persons insured through the facility identical to those established pursuant to chapter 21 for persons insured voluntarily.

(e) Establish procedures and guidelines for the issuance of binders by agents upon receipt of the application for coverage.

(f) Provide for the issuance of policies of automobile insurance to qualified applicants whose licenses to operate a vehicle have been suspended pursuant to section 310, 310b, 310d, 315, 321a, 324, 328, 512, 515, 625, 625f, 748, 801c, or 907 of Act No. 300 of the Public Acts of 1949, as amended, being sections 257.310, 257.310b, 257.310d, 257.315, 257.321a, 257.324, 257.328, 257.512, 257.515, 257.625, 257.625f, 257.748, 257.801c, and 257.907 of the Michigan Compiled Laws, as provided in the plan of operation. These policies may be canceled after a period of not less than 30 days if the insured fails to produce proof that the suspended license has been reinstated.

(3) Automobile insurance made available under this section shall be equivalent to the automobile insurance normally available in the voluntary competitive market in forms as approved by the commissioner with such changes, additions, and amendments as are adopted by the board of governors and approved by the commissioner.

Sec. 3330. (1) The board of governors shall have all power to direct the operation of the facility, including, at a minimum, all of the following:

(a) To sue and be sued in the name of the facility. A judgment against the facility shall not create any liabilities in the individual participating members of the facility.

(b) To delegate ministerial duties, to hire a manager, to hire legal counsel, and to contract for goods and services from others.

(c) To assess participating members on the basis of participation ratios pursuant to section 3303 to cover anticipated costs of operation and administration of the facility, to provide for equitable servicing fees, and to share losses, profits, and expenses pursuant to the plan of operation.

(d) To impose limitations on cancellation or nonrenewal by participating members of facility-placed business, in addition to the limitations imposed by chapters 21 and 32.

(e) To provide for a limited number of participating members to receive equitable distribution of applicants; or to provide for a limited number of participating members to service applicants in a plan of sharing of losses in accordance with section 3320(2)(c) and the plan of operation.

(f) To provide for standards of performance of service for the participating members designated pursuant to subdivision (e).

(g) To adopt a plan of operation and any amendments to the plan, not inconsistent with this chapter, necessary to assure the fair, reasonable, equitable, and nondiscriminatory manner of administering the facility, including compliance with chapter 21, and to provide for such other matters as are necessary or advisable to implement this chapter, including matters necessary to comply with the requirements of chapter 21.

(h) To provide for servicing fees.

(2) The board of governors shall institute or cause to be instituted by the facility or on its behalf an automatic data processing system for recording and compiling data relative to individuals insured through the facility. An automatic data processing system established under this subsection shall, to the greatest extent possible, be made compatible with the automatic data processing system maintained by the secretary of state, to provide for the identification and review of individuals insured through the facility.

Sec. 3340. (1) As agent for participating members, the facility shall file with the commissioner every manual of classification, every manual of rules and rates, every rating plan and every modification of a manual of classification, manual of rules and rates, or rating plan proposed for use for private passenger nonfleet automobile insurance placed through the facility. The facility may incorporate by reference in its filings other material on file with the commissioner. The classifications, rules and rates, and any amendments thereof shall be subject to prior written approval by the commissioner. Except as provided in this chapter, rates filed by the facility for private passenger nonfleet automobile insurance shall be in accordance with chapter 21 and rates by the facility for all other automobile insurance shall be filed in accordance with chapter 24.

(2) Every participating member designated to act on behalf of the facility shall be authorized to use the rates and rules approved by the commissioner for use by the facility on business placed through the facility and shall not use other rates for automobile insurance placed through the facility.

(3) Laws relating to rating organizations or advisory organizations shall not apply to functions provided for under this section.

(4) Private passenger nonfleet automobile rates for the facility shall comply with the following requirements:

(a) The territories for the facility shall be defined as those of the principal rating organization or principal advisory organization for the voluntary market.

(b) The rates for the facility shall conform with the requirements of chapter 21 governing voluntary market rates.

(5) If it appears that the income to be derived by the facility from premiums paid by policyholders and from investment income is not adequate to cover the anticipated losses and expenses for the facility's fiscal year, the facility shall immediately increase premiums, reduce administrative expenses and servicing carrier fees, or both, as approved by the commissioner in order to assure that the facility continues to be self-supporting.

Sec. 3355. Every agent who is authorized to solicit, negotiate or effect automobile insurance on behalf of any participating member shall:

(a) Offer to place automobile insurance through the facility for any qualified applicant requesting the agent to do so.

(b) If the qualified applicant accepts the offer in subdivision (a), forward the application and any deposit premium required in accordance with the plan of operation, rules, and procedures of the facility.

(c) Be entitled to receive, and any participating member be entitled to pay, a commission for placing insurance through the facility at the uniform rates of commission as provided in the plan of operation which, effective 300 days after the effective date of the amendatory act that added section 3340(5), shall not be greater than 5% for insurance for eligible drivers placed through the facility.

Sec. 7911. (1) To implement this chapter, there shall be maintained within this state, by all insurers authorized to transact in this state insurance other than life or disability insurance, except the Michigan basic property insurance association created pursuant to section 2920 and on and after June 29, 1990, the accident fund created in the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being sections 418.101 to 418.941 of the Michigan Compiled Laws, an association of those insurers to be known as the property and casualty guaranty association, hereafter referred to as the "association". Each insurer shall be a member of the association as a condition of its authority to continue to transact insurance in this state.

(2) An insurer from which insurance has been or may be procured in this state solely by virtue of sections 1901 to 1955 shall not be considered to be an insurer authorized to transact insurance in this state for the purposes of this chapter.

(3) The association shall be subject to the requirements of this chapter, chapter 78, and section 3172a, but shall not be subject to the other chapters of this act. The association shall be subject to other laws of this state to the extent that it would be subject to those laws if it were an insurer organized and operating under chapter 50, to the extent that those other laws are consistent with this chapter.

Co-Clerk of the House of Representatives.

Secretary of the Senate.

Approved _____

Governor.